# PERS Select

## Medicare Part D Prescription Drug Coverage

### Preferred Provider Organization

PERS Select

Evidence of Coverage Medicare Prescription Drug Plan (PDP)

**Effective January 1, 2016 – December 31, 2016**

A Self-Funded Medicare Health Benefit Plan Administered by the CalPERS Board Pursuant to the Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

**January 1, 2016 – December 31, 2016**

# Evidence of Coverage:

## Your Medicare Prescription Drug Coverage as a Member of PERS Select Supplement to Original Medicare Plan sponsored by the California Public Employees' Retirement System (CalPERS)

This booklet gives you the details about your primary Medicare Part D prescription drug coverage from **January 1, 2016 – December 31, 2016**. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.** This document describes your primary Medicare Part D Benefit. You also have supplemental prescription drug coverage provided by CalPERS, which is described in Chapter 9 of this *Evidence of Coverage* or call CVS/caremark Customer Care at 1-855-479-3660, 24 hours a day, 7 days a week. TTY users should call 711.

This plan, PERS Select Medicare Part D Prescription Drug Plan (PERS Select Medicare Part D PDP) sponsored by CalPERS, is offered by CVS/caremark. (When this *Evidence of Coverage* says "we," "us," or "our," it means CVS/caremark. When it says "plan" or "our plan," it means PERS Select Medicare Part D PDP.)

CalPERS has an Employer Group Waiver Plan (EGWP) for Medicare-eligible retirees. This plan is administered by CVS/caremark. This means that Medicare-eligible retirees and/or dependents have been enrolled in a Group Medicare Part D Plan. CalPERS, through PERS Select Supplement to Original Medicare Plan, is providing you a pharmacy plan, which supplements the Part D Plan so you have the same level of benefits as before with your PERS Select Plan.

CVS/caremark (Employer PDP) is a Prescription Drug Plan (PDP). This plan has a Medicare contract and enrollment depends on contract renewal.

This information is available for free in other languages. Please contact our CVS/caremark Customer Care number at 1-855-479-3660 for additional information. (TTY users should call 711.) Hours are 24 hours a day, 7 days a week. CVS/caremark Customer Care also has free language interpreter services available for non-English speakers (phone numbers are printed on the last page of this booklet).

Esta información está disponible gratuitamente en otros idiomas. Comuníquese con nuestro Cuidado al Cliente CVS/caremark, al 1-855-479-3660 para obtener información adicional. (Los usuarios de teléfono de texto (TTY) deben llamar al 711.) El horario es las 24 horas al día, los 7 días de la semana. El Cuidado al Cliente CVS/caremark también tiene servicios gratuitos de interpretación disponibles para personas que no hablan inglés (los números telefónicos se encuentran en la contraportada de este folleto).

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Form CMS 10260-ANOC/EOC
(Approved 03/2014)

OMB Approval 0938-1051

This information is available in a different format, including Braille, large print, and audio formats. Please call CVS/caremark Customer Care if you need plan information in another format.

Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2017.

Your privacy is important to us. CVS/caremark employees are trained regarding the appropriate way to handle your private health information.

# 2016 Evidence of Coverage

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# CHAPTER 1

## *Getting started as a member*

# Chapter 1. Getting started as a member

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# SECTION 1 Introduction

## Section 1.1 You are enrolled in PERS Select Medicare Part D Prescription Drug Plan (PDP), which is a Medicare Prescription Drug Plan

**Please note: This prescription coverage is offered in conjunction with your medical coverage. If you choose a Medicare Prescription Drug Plan other than PERS Select Medicare Part D PDP, you cannot be enrolled in the PERS Select Supplement to Original Medicare Plan and you will lose your CalPERS medical benefits**.

There are different types of Medicare plans. PERS Select Medicare Part D PDP, administered by CVS/caremark, is a Medicare Prescription Drug Plan (PDP). Like all Medicare plans, this Medicare Prescription Drug Plan is approved by Medicare and administered by a private company.

## Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of PERS Select Medicare Part D PDP. It is important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

## Section 1.3 Legal information about the *Evidence of Coverage*

### It is part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how PERS Select Medicare Part D PDP covers your care. Other parts of this contract include the *List of Covered Drugs (Formulary)* and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in PERS Select Medicare Part D PDP between January 1, 2016 and December 31, 2016.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of PERS Select Medicare Part D PDP after December 31, 2016. We can also choose to stop offering the plan, or offer it in a different service area, after December 31, 2016.

### Medicare must approve our plan each year

The Centers for Medicare & Medicaid Services (Medicare) must approve PERS Select Medicare Part D PDP each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

## SECTION 2 What makes you eligible to be a plan member?

### Section 2.1 Your eligibility requirements

*You are eligible for membership in our plan as long as you meet the following requirements:*

- CalPERS has determined that you are eligible for this plan.
- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B). Section 2.2 tells you about Medicare Part A and Medicare Part B.
- -- *and* -- You live in our geographic service area (Section 2.3 describes our service area).

### Section 2.2 What are Medicare Part A and Medicare Part B?

As discussed in Section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through our plan. Our plan has contracted with Medicare to provide you with most of these Medicare benefits. We describe the drug coverage you receive under your Medicare Part D coverage in Chapter 3.

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physicians' services and other outpatient services) and certain items (such as durable medical equipment and supplies).

### Section 2.3 Here is the plan service area for PERS Select Medicare Part D PDP

Medicare is a Federal program and PERS Select Medicare Part D PDP is available only to CalPERS members who reside in the United States or its territories. To remain a member of our plan, you must reside in the United States or its territories. Please note: You will need a physical address on file with CalPERS to be enrolled in the plan.

If you plan to move out of the service area, please contact CalPERS and CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet). When you move,

you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call the Social Security Administration if you move or change your mailing address. You can find phone numbers and contact information for the Social Security Administration in Chapter 2, Section 5.

## SECTION 3 What other materials will you receive from us?

### Section 3.1 Your plan membership card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your membership card for our plan for prescription drugs you get at network pharmacies. Here is a sample membership card to show you what yours will look like:

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call CVS/caremark **Customer Care right away and we will send you a new card. (Phone numbers for CVS/caremark** Customer Care are printed on the last page of this booklet.)

You may need to use your existing red, white, and blue Medicare card and medical carrier card to get covered medical care and services under Original Medicare.

### Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network

Every year that you are a member of our plan, we will send you either a new *Pharmacy Directory* or an update to your *Pharmacy Directory*. This directory lists our network pharmacies.

### What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

### Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

The *Pharmacy Directory* will also tell you which of the pharmacies in our network have "preferred cost sharing," which may be lower than the standard cost sharing offered by other network pharmacies.

There may be changes to our preferred network of pharmacies for next year. **Please review the 2016 *Pharmacy Directory* to see which pharmacies are in our network.**

If you do not have the *Pharmacy Directory*, you can get a copy from CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet). At any time, you can call CVS/caremark Customer Care to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.caremark.com/calpers.

## Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D and CalPERS supplemental prescription drugs are covered by PERS Select Medicare Part D PDP. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the PERS Select Medicare Part D PDP Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact CVS/caremark Customer Care to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.caremark.com/calpers) or call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

### Section 3.4 The *Part D Explanation of Benefits* (the "Part D EOB"): A summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

## SECTION 4 Your monthly premium for PERS Select Medicare Part D PDP

### Section 4.1 How much is your plan premium?

CalPERS is responsible for paying any monthly plan premium, if applicable, to the plan. Please contact CalPERS for information about your plan premium. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

#### In some situations, your plan premium could be <u>less</u>

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, the **information about premiums in this *Evidence of Coverage* may not apply to you**. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you do not get Extra Help and did not receive this insert with this packet, please call CVS/caremark Customer Care and ask for the "LIS Rider." (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)

### If you pay a premium, then in some situations, your plan premium could be more

In some situations, your plan premium could be more. These situations are described below. Some members are required to pay a **Late Enrollment Penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they did not have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The Late Enrollment Penalty will be part of your plan premium. If you do not pay the Late Enrollment Penalty amount, you will be disenrolled from PERS Select Medicare Part D PDP. Therefore, to avoid disenrollment, make sure your Late Enrollment Penalty is paid.

- If you are required to pay a Late Enrollment Penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 4, Section 9 explains the Late Enrollment Penalty.
- If you have a Late Enrollment Penalty, you will receive a monthly invoice from CVS/caremark. If you do not pay the monthly Late Enrollment Penalty premium, you could be disenrolled for failure to pay your plan premium. Therefore, to avoid disenrollment, make sure your Late Enrollment Penalty is paid.

### Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. Some plan members (those who are not eligible for premium-free Part A) pay a premium for Medicare Part A and some plan members may pay a premium for Medicare Part B.

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amount, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately), or greater than $170,000 for married couples, **you must pay an extra amount directly to the Social Security Administration (not the Medicare plan)** for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, the Social Security Administration, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.

For more information about Part D premiums based on income, go to Chapter 4, Section 10 of this booklet. You can also visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2016* gives information about the Medicare premiums in the section called "2016 Medicare Costs." This explains how the Medicare Part B and Part D

premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You 2016* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2016* from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### Section 4.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. CalPERS is responsible for paying any monthly plan premium, if applicable, to the plan. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

## SECTION 5 Please keep your plan membership record up to date

### Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

**Let us know about these changes:**

- Changes to your name, address, or phone number
- Changes in any other medical or drug insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, or Medicaid
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home or long-term care (LTC) facility
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

It is also important to contact the Social Security Administration if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5. You must also contact CalPERS with any name or address changes.

### Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you do not need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

## SECTION 6 We protect the privacy of your personal health information

### Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

## SECTION 7 How other insurance works with our plan

### Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like other employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

  - If you are under 65 and disabled and you or your family member are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you are over 65 and you or your spouse are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

# CHAPTER 2

## *Important phone numbers and resources*

# Chapter 2. Important phone numbers and resources

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## SECTION 1 CVS/caremark Customer Care contacts (how to contact us, including how to reach CVS/caremark Customer Care at the plan)

### How to contact our plan's CVS/caremark Customer Care

For assistance with claims, billing, or member card questions, please call or write to CVS/caremark Customer Care. We will be happy to help you.

| CVS/caremark Customer Care – Contact Information | |
|---|---|
| **CALL** | 1-855-479-3660<br>Calls to this number are free. Available 24 hours a day, 7 days a week.<br>CVS/caremark Customer Care also has free language interpreter services available for non-English speakers. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |
| **FAX** | 1-888-472-1129 |
| **WRITE** | CVS/caremark<br>P.O. Box 52067<br>Phoenix, AZ 85072-2067 |
| **WEBSITE** | www.caremark.com/calpers |

### How to contact the plan when you are asking for a coverage decision or making an appeal about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint [coverage decisions, appeals, complaints]*).

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint [coverage decisions, appeals, complaints]*).

You may call us if you have questions about our coverage decision or appeals processes.

**You have specific coverage request rules and appeal rights for drugs covered by your CalPERS supplemental coverage. Your coverage request rules and appeal rights can be found in Chapter 9.**

| Coverage Decisions and Appeals for Part D Prescription Drugs – Contact Information | |
|---|---|
| **CALL** | 1-855-479-3660<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |
| **FAX** | 1-855-633-7673 |
| **WRITE** | CVS/caremark Medicare Part D Appeals Department<br>P.O. Box 52000, MC 109<br>Phoenix, AZ 85072-2000 |
| **WEBSITE** | www.caremark.com/calpers |

### How to contact us when you are making a complaint about your Part D PDP or pharmacy

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint [coverage decisions, appeals, complaints]*).

| Complaints About Your Part D PDP or Pharmacy – Contact Information | |
|---|---|
| **CALL** | 1-855-479-3660<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |
| **FAX** | 1-866-217-3353 |
| **WRITE** | CVS/caremark Medicare Part D – Grievances<br>P.O. Box 53991, MC 121<br>Phoenix, AZ 85072-3991 |
| **MEDICARE WEBSITE** | You can submit a complaint about PERS Select Medicare Part D PDP administered by CVS/caremark directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx. |

### Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking the plan to pay its share of the costs for covered drugs*).

**Please note:** If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint [coverage decisions, appeals, complaints]*) for more information.

| Payment Requests – Contact Information | |
|---|---|
| **CALL** | 1-855-479-3660<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |
| **WRITE** | Medicare Part D Paper Claims<br>P.O. Box 52066<br>Phoenix, AZ 85072-2066 |
| **WEBSITE** | www.caremark.com/calpers |

## SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Prescription Drug Plans, including us.

| Medicare – Contact Information | |
|---|---|
| **CALL** | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |
| **TTY** | 1-877-486-2048<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 24 hours a day, 7 days a week. |

| | |
|---|---|
| **WEBSITE** | www.medicare.gov<br><br>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.<br><br>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:<br><br>• **Medicare Eligibility Tool:** Provides Medicare eligibility status information.<br><br>• **Medicare Plan Finder:** Provides personalized information about available Medicare Prescription Drug Plans, Medicare Health Plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.<br><br>You can also use the website to tell Medicare about any complaints you have about PERS Select Medicare Part D PDP.<br><br>• **Tell Medicare about your complaint:** You can submit about PERS Select Medicare Part D PDP directly to Medicare. To submit a complaint, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.<br><br>If you do not have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE [1-800-633-4227], available 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) |

## SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

| HICAP (California's SHIP) – Contact Information | |
|---|---|
| **CALL** | 1-800-434-0222<br>Calls to this number are free. Available 9 a.m. to 4 p.m., Monday through Friday. |
| **TTY** | 1-800-735-2929<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 9 a.m. to 4 p.m., Monday through Friday. |
| **WRITE** | Health Insurance Counseling and Advocacy Program (HICAP)<br>1300 National Drive, Suite 200<br>Sacramento, CA 95834 |
| **WEBSITE** | www.aging.ca.gov/HICAP |

If you live outside of California, you can contact CVS/caremark Customer Care at 1-855-479-3660, 24 hours a day, 7 days a week, for assistance finding your state's SHIP. TTY users should call 711.

## SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Please call CVS/caremark Customer Care for the contact information of the Quality Improvement Organization in your state. (CVS/caremark Customer Care phone numbers are printed on the last page of this booklet.)

Quality Improvement Organizations have a group of doctors and other health care professionals who are paid by the Federal government. These organizations are paid by

Medicare to check on and help improve the quality of care for people with Medicare. Quality Improvement Organizations are independent organizations. They are not connected with our plan.

You should contact your Quality Improvement Organization if you have a complaint about the quality of care you have received. For example, you can contact your Quality Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

| **Livanta BFCC-QIO Program (California's Quality Improvement Organization) – Contact Information** | |
|---|---|
| **CALL** | 1-877-588-1123<br>Calls to this number are free. Available 9 a.m. to 5 p.m., Monday through Friday; 11 a.m. to 3 p.m., Saturday and Sunday. |
| **TTY** | 1-855-887-6668<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 9 a.m. to 5 p.m., Monday through Friday; 11 a.m. to 3 p.m., Saturday and Sunday. |
| **WRITE** | Livanta BFCC-QIO Program<br>9090 Junction Drive, Suite 10<br>Annapolis Junction, MD 20701 |
| **WEBSITE** | www.bfccqioarea5.com |

## SECTION 5 Social Security Administration

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security Administration checks, enrollment into Medicare is automatic. If you are not getting Social Security Administration checks, you have to enroll in Medicare. The Social Security Administration handles the enrollment process for Medicare. To apply for Medicare, you can call the Social Security Administration or visit your local Social Security Administration office.

The Social Security Administration is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you received a letter from the Social Security Administration telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a

life-changing event, you can call the Social Security Administration to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security Administration to let them know.

| Social Security Administration – Contact Information | |
|---|---|
| **CALL** | 1-800-772-1213<br>Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.<br>You can use the Social Security Administration's automated telephone services to get recorded information and conduct some business 24 hours a day. |
| **TTY** | 1-800-325-0778<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. |
| **WEBSITE** | www.ssa.gov |

## SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. In California, this program is called Medi-Cal. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medi-Cal that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits [QMB+].)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits [SLMB+].)
- **Qualified Individual (QI):** Helps pay Part B premiums.

- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medi-Cal, please call the California Department of Healthcare Services or contact CVS/caremark Customer Care. To find out more about other state Medicaid programs contact CVS/caremark Customer Care.

| California Department of Healthcare Services – Contact Information | |
|---|---|
| **CALL** | 1-800-541-5555<br>Calls to this number are free. Available 8 a.m. to 5 p.m., Monday through Friday. |
| **TTY** | 1-800-735-2929<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. Available 8 a.m. to 5 p.m., Monday through Friday. |
| **WRITE** | California Department of Health Services<br>P.O. Box 997413, MS4400<br>Sacramento, CA 95899-7413 |
| **WEBSITE** | www.dhcs.ca.gov |

## SECTION 7 Information about programs to help people pay for their prescription drugs

### Medicare's Extra Help Program

Medicare provides Extra Help to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium and prescription copayments *or* coinsurance. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and do not need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (use prompt word "applications"); or
- Your State Medicaid Office (use prompt word "applications"). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level or, if you already have the evidence, to provide this evidence to us.

- PERS Select Medicare Part D PDP will accept any of the following documents as evidence:
    - A copy of your Medicaid card, which includes your name and eligibility date during the period for which you believe you qualified for Extra Help;
    - Details of any call you made to verify your Medicaid status, including the date a verification call was made to the State Medicaid Agency and the name, title, and telephone number of the state staff person who verified your Medicaid status during the discrepant period;
    - A copy of a state document that confirms your active Medicaid status during the discrepant period;
    - A print out from the state electronic enrollment file showing your Medicaid status during the discrepant period;
    - A screen-print from the state's Medicaid systems showing your Medicaid status during the discrepant period;
    - Other documentation provided by the state showing your Medicaid status during the discrepant period;
    - A letter from the Social Security Administration (SSA) showing that the individual receives Supplemental Security Income (SSI); or,
    - An "Important Information" letter from SSA confirming that the beneficiary is automatically eligible for Extra Help.
- Documentation from the state or SSA showing your low-income subsidy level is the preferred evidence of your proper cost-sharing level. Please fax your documentation to us at 1-866-552-6205. Please include a phone number where we can contact you. If you cannot provide the documentation and need assistance or would like additional information, contact CVS/caremark Customer Care, 24 hours a day, 7 days a week, at 1-855-479-3660. TTY users should call 711.
- For beneficiaries that are institutionalized and qualify for zero cost sharing, the following documents will be accepted as evidence of your proper cost-sharing level:

  - A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
  - A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
  - A screen-print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy has not collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact CVS/caremark Customer Care if you have questions (phone numbers are printed on the last page of this booklet).

### Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program is available nationwide. CalPERS provides supplemental prescription drug coverage for you during the Coverage Gap phase, so the discount program does not apply to you.

Instead, the plan continues to cover your drugs at the applicable copayment until you qualify for the Catastrophic Coverage Stage. Please see Chapter 4, Section 5 for more information about your coverage during the Initial Coverage Stage.

### AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) helps eligible individuals living with HIV/AIDS. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV-positive status, low income as defined by the state, and being uninsured/under-insured.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For information on eligibility criteria, covered drugs or how to enroll in the program, please contact the California Office of Aids at 1-916-449-5900, 8 a.m. to 5 p.m., Monday through Friday (PST).

## SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

| Railroad Retirement Board – Contact Information | |
|---|---|
| **CALL** | 1-877-772-5772<br>Calls to this number are free. Available 9 a.m. to 3:30 p.m., Monday through Friday.<br>If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays. |
| **TTY** | 1-312-751-4701<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are *not* free. Available 9 a.m. to 3:30 p.m., Monday through Friday. |
| **WEBSITE** | www.rrb.gov |

## SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group other than CalPERS as part of this plan, you may call the employer/union benefits administrator or CVS/caremark Customer Care if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, with questions related to your Medicare coverage under this plan. TTY users should call 1-877-486-2048.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

# CHAPTER 3

## *Using the plan's coverage for your Part D prescription drugs*

# Chapter 3. Using the plan's coverage for your Part D prescription drugs

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### Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include the Extra Help program, which helps people with limited resources pay for their drugs, and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

### Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you get Extra Help and did not receive this insert with this packet, please call CVS/caremark Customer Care and ask for the "LIS Rider." (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)

## SECTION 1 Introduction

### Section 1.1 This chapter describes your coverage for Part D drugs

This chapter **explains rules for using your coverage for Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 4, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2016* handbook.) The medical coverage provided by your employer group may cover a supply of these drugs.

### Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write your prescription.

- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- In most circumstances, you must use a network pharmacy to fill your prescription or you must submit a paper claim form to us. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

## SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

### Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Our network includes pharmacies that offer standard cost sharing and pharmacies that offer preferred cost sharing. You may go to either preferred network pharmacies or other network pharmacies to receive your covered prescription drugs. Your cost sharing may be less at pharmacies with preferred cost sharing.

**You can change your 30-day supplies to 90-day supplies at preferred network pharmacies.**

If you are currently taking any long-term medications[1], you do not have to change from 30-day supplies to 90-day supplies. However, ordering a 90-day supply from a CVS/pharmacy® may cost less than three 30-day supplies of the prescription drug from a non-CVS/pharmacy. Considering the long-term nature of your prescription, changing from 30-day supplies to ordering 90-day supplies at a CVS/pharmacy could save you money.

[1]Long-term medications are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes, or high cholesterol.

**You can choose from two 90-day refill options for the same low price.**

**Option 1: Refill at any CVS/pharmacy.** Fill your 90-day supply at any CVS/pharmacy location and pick up your medications at your convenience.

**Option 2: Refill with CVS/caremark Mail Service Pharmacy.** Have a 90-day supply of your long-term medications shipped to your home.

## Section 2.2 Finding network pharmacies

### How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.caremark.com/calpers), or call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

You may go to any of our network pharmacies. However, your costs may be lower for your covered drugs if you use a network pharmacy that offers preferred cost sharing rather than a network pharmacy that offers standard cost sharing. The *Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. You can find out more about how your out-of-pocket costs could vary for different prescription drugs by contacting us.

If you switch from one network pharmacy to another and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

### What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network or you must submit a paper claim form to us. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a new pharmacy. To find another network pharmacy in your area, you can get help from CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.caremark.com/calpers.

### What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the

pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact CVS/caremark Customer Care.

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

## Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The prescription drugs that are *not* available through the plan's mail-order service are marked as **"NM" for not available at mail** in our Drug List.

Our plan's mail-order service allows you to order **up to a 90-day supply.**

To get order forms and information about filling your prescriptions by mail, visit our website (www.caremark.com/calpers) or contact CVS/caremark Customer Care (phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet).

Usually a mail-order pharmacy order will get to you in no more than 10 days. If the mail-order pharmacy expects a delay of more than 10 days, they will contact you and help you decide whether to wait for the medication, cancel the mail-order, or fill the prescription at a local pharmacy. If your order does not reach you within 10 days, you may contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

**New prescriptions the pharmacy receives directly from your doctor's office.** After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy to let them know what to do with the new prescription and 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 called ReadyFill at Mail®. 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. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and 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 auto 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 ReadyFill at Mail, which automatically prepares mail-order refills, please contact us by calling CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please call CVS/caremark Customer Care to give us your preferred phone number (phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet).

## Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies may agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of maintenance drugs. In this case, you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call CVS/caremark Customer Care for more information (phone numbers are printed on the last page of this booklet).
2. For certain kinds of drugs, you can use the plan's network **mail-order services.** The drugs that are *not* available through the plan's mail-order service are marked as **"NM" for not available at mail** in our Drug List. Our plan's mail-order service requires you to order at least a 60-day supply of the drug and no more than a 90-day supply. See Section 2.3 for more information about using our mail-order services.

## Section 2.5 When can you use a pharmacy that is not in the plan's network?

### Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out of stock at an accessible network retail or mail-service pharmacy (including high-cost and unique drugs).

- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.

If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more than you would have paid if you had gone to an in-network pharmacy.

In these situations, **please check first with CVS/caremark Customer Care** to see if there is a network pharmacy nearby. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

### How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. You must submit a paper claim in order to be reimbursed. (Chapter 5, Section 2.1 in the *Evidence of Coverage* explains how to ask the plan to pay you back.)

## SECTION 3 Your drugs need to be on the plan's "Drug List"

### Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In the *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. "Medically accepted indication" is a use of a drug that is *either:*

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed); or
- Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

PERS Select Medicare Part D PDP does not cover drugs or supplies that are covered under Medicare Part B as prescribed and dispensed. CalPERS, however, is providing supplemental coverage to this plan for drugs that would normally be covered under Medicare Part B. In addition, CalPERS has also elected to cover some drugs and supplies that are not covered under Medicare Part D, including certain Diabetic supplies, some Barbiturates, some Benzodiazepines, prescription Cough and Cold medications, and Sexual or Erectile Dysfunction drugs. For Sexual or Erectile Dysfunction drugs, quantity limits and 50% coinsurance apply.

### The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

### What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

## Section 3.2 There are three "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Cost-Sharing Tier 1: Generic Drugs (lowest cost-sharing tier)**
- **Cost-Sharing Tier 2: Preferred Brand Drugs**
- **Cost-Sharing Tier 3: Non-Preferred Brand Drugs**

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

**Please note:** CalPERS provides supplemental coverage that may differ in structure from the primary benefit and also cover additional medications. There may be instances where your cost share may be more or less due to this supplemental coverage. If you are unsure about the cost share on the supplemental coverage, or which drugs may or may not be covered, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

### Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail for information on your drug coverage. (**Please note:** The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact CVS/caremark Customer Care to find out if we cover it.)
2. Visit the plan's website (www.caremark.com/calpers). The Drug List on the website is always the most current.
3. Call CVS/caremark Customer Care to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)

## SECTION 4 There are restrictions on coverage for some drugs

### Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our Drug List. This is because different restrictions or cost sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

## Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. This section tells you more about the types of restrictions we use for certain drugs on your plan.

### Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

### Getting plan approval in advance (Prior Authorization)

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes, the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

### Trying a different drug first (Step Therapy)

This requirement encourages you to try less costly, but just as effective, drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy."**

### Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

## Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet) or check our website (www.caremark.com/calpers).

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** If there is a restriction on the drug you

want to take, you should contact CVS/caremark Customer Care to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

## SECTION 5 What if one of your drugs is not covered in the way you would like it to be covered?

### Section 5.1 There are things you can do if your drug is not covered in the way you would like it to be covered

We hope that your prescription drug coverage will work well for you. But it is possible that there could be a prescription drug you are currently taking, or one that you or your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or, maybe a generic version of the drug is covered, but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use.
    - For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
        - In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or, you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be. The plan puts each covered drug into one of three different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List, or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

## Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

CalPERS is providing supplemental coverage to your Medicare Part D Prescription Drug Plan. This drug may be covered under this supplemental coverage. For more information on your coverage, please contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

If your drug is not on the Drug List, or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

### You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

**1. The change to your drug coverage must be one of the following types of changes:**

- The drug you have been taking is **no longer on the plan's Drug List**; or
- The drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

**2. You must be in one of the situations described below:**

- **For those members who are new or who were in the plan last year and are not in a long-term care (LTC) facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year**. The total supply will be for a maximum of a 102-day supply, depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 102-day supply of medication. (Please note that the long-term care pharmacy may provide the prescription drug in smaller amounts at a time to prevent waste.)

- **For those who have been a member of the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one 34-day supply of a particular prescription drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- If you experience a change in your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary or if your ability to get your drugs is limited, we may cover a one-time temporary supply from a network pharmacy for up to 30 days (or 34 days if you are a long-term care facility resident) unless you have a prescription for fewer days. You should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

To ask for a temporary supply, call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

### You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call CVS/caremark Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)

### You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or, you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can ask for an exception before next year, and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

## Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

### You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call CVS/caremark Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)

### You can ask for an exception

For drugs in Tier 3: Non-Preferred Brand Drugs, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Tier 1: Generic Drugs (lowest cost-sharing tier) or Tier 2: Preferred Brand Drugs.

### Preferred and Non-Preferred Brand Name Drugs

CVS/caremark's Pharmacy and Therapeutics Committee reviews tier placement each quarter. If new generics have become available, new clinical studies have been released, new brand name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug. If your doctor believes a non-preferred brand name drug that has a generic equivalent is medically necessary, he/she will need to complete the "Member Pays the Difference Request Form." Forms are available by contacting CVS/caremark Customer Care at 1-855-479-3660. Have your doctor complete the form and fax it to CVS/caremark. If approved, you will pay the Preferred Brand copay amount.

## SECTION 6 What if your coverage changes for one of your drugs?

### Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or, we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

### Section 6.2 What happens if coverage changes for a drug you are taking?

#### How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it has been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change and can work with you to find another drug for your condition.

### Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change will not affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably will not see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
    - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
    - Or, you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint [coverage decisions, appeals, complaints]*).
- If a drug is **suddenly recalled** because it has been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
    - Your provider will also know about this change and can work with you to find another drug for your condition.

## SECTION 7 What types of drugs are *not* covered by the plan?

CalPERS has elected to cover certain drugs not covered under Medicare Part D as described and dispensed as part of a supplemental benefit. These are not subject to the appeals and exceptions process below. The coverage request rules and appeal process for your CalPERS supplemental coverage is in Chapter 7, or you can contact CVS/caremark Customer Care for any questions regarding your supplemental benefit.

## Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We will not pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7, Section 5.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

PERS Select Medicare Part D PDP offers additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan (supplemental prescription drug

coverage). The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.)

The following lists drugs that are excluded from CalPERS supplemental coverage:

1. Non-medical therapeutic devices, durable medical equipment, appliances and supplies, including support garments, even if prescribed by a physician, regardless of their intended use.*
2. Drugs not approved by the U.S. Food and Drug Administration (FDA).
3. Off-label use of FDA approved drugs**, if determined inappropriate through CVS/caremark's Coverage Management Programs.
4. Any quantity of dispensed medications that is determined inappropriate as determined by the FDA or through CVS/caremark's Coverage Management Programs.
5. Drugs or medicines obtainable without a prescriber's prescription, often called over-the-counter (OTC) drugs or behind-the-counter (BTC) drugs, except insulin, diabetic test strips and lancets, and Plan B.
6. Dietary and herbal supplements, minerals, health aids, homeopathics, any product containing a medical food, and any vitamins, whether available over the counter or by prescription (e.g., prenatal vitamins, multi-vitamins, and pediatric vitamins), except prescriptions for single agent vitamin D, vitamin K, and folic acid.
7. A prescription drug that has an over-the-counter alternative.
8. Anorexiants and appetite suppressants or any other anti-obesity drugs.
9. Supplemental fluorides (e.g., infant drops, chewable tablets, gels, and rinses).
10. Charges for the purchase of blood or blood plasma.
11. Hypodermic needles and syringes, except as required for the administration of a covered drug.
12. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
13. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved investigational drugs. Any drug or medication prescribed for experimental indications.
14. Any drugs prescribed solely for the treatment of an illness, injury, or condition that is excluded under the plan.
15. Any drugs or medications which are not legally available for sale within the United States.
16. Any charges for injectable immunization agents (except when administered at a Participating Pharmacy), desensitization products or allergy serum, or biological sera, including the administration thereof.*
17. Professional charges for the administration of prescription Drugs or injectable insulin.*

18. Drugs or medicines, in whole or in part, to be taken by, or administered to, a plan member while confined in a hospital or skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility.*
19. Drugs and medications dispensed or administered in an outpatient setting (e.g., injectable medications), including, but not limited to, outpatient hospital facilities, and services in the member's home provided by home health agencies and home infusion therapy providers.*
20. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or medication furnished by any other drug or medical services for which no charge is made to the plan member.
21. Any quantity of dispensed drugs or medicines, which exceeds a thirty (30) day supply at any one time, unless obtained through CVS/caremark Mail Service Pharmacy or the Maintenance Choice program. Prescriptions filled using CVS/caremark Mail Service Pharmacy or the Maintenance Choice program are limited to a maximum ninety (90) day supply of covered drugs or medicines as prescribed by a prescriber. Specialty medications are limited up to a 30-day supply.
22. Refills of any prescription in excess of the number of refills specified by a prescriber.
23. Any drugs or medicines dispensed more than one (1) year following the date of the prescriber's prescription order.
24. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a Non-Participating Pharmacy, or the CVS/caremark Mail Service Pharmacy program.
25. Compounded medications if: (1) there is a medically appropriate formulary alternative, or (2) the compounded medication contains any ingredient not approved by the FDA. Compounded medications that do not include at least one covered prescription drug will not be covered.
26. Replacement of lost, stolen, or destroyed prescription drugs.

*While not covered under this plan, these items may be covered by your medical plan. See your medical plan's EOC for more information.

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

**Services Covered by Other Benefits**

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

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call CVS/caremark Customer Care for more information. Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6 in the *Evidence of Coverage*.)

## SECTION 8 Show your plan membership card when you fill a prescription

### Section 8.1 Show your membership card

To fill your prescription, show your PERS Select Medicare Part D PDP membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. This includes any supplemental coverage being provided by CalPERS. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

### Section 8.2 What if you do not have your membership card with you?

If you do not have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

## SECTION 9 Part D drug coverage in special situations

### Section 9.1 What if you are in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

**Please Note:** When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 8 (*Ending your membership in the plan*) tells when you can leave our plan and join a different Medicare plan.)

## Section 9.2 What if you are a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

### What if you are a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 102-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 34-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or, you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

## Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in PERS Select Medicare Part D PDP does not affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan cannot cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through PERS Select Medicare Part D PDP in other situations, but drugs are never covered by both Part B and our

plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or PERS Select Medicare Part D PDP for the drug.

**CalPERS is providing supplemental coverage for drugs that would normally be covered under Medicare Part B. For more information, please contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).**

## Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you did not get this notice, or if you cannot find it, contact your Medigap insurance company and ask for another copy.

## Section 9.5 What if you are also getting drug coverage from an employer or retiree group plan?

In addition to your coverage in PERS Select Medicare Part D PDP, do you currently have other prescription drug coverage other than PERS Select Medicare Part D PDP through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

### Special note about "creditable coverage":

If you currently have other prescription drug coverage other than PERS Select Medicare Part D PDP, that group's benefit administrator should send you a notice that tells you if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

**Keep these notices about creditable coverage** because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you did not get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

### Section 9.6 What if you are in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D Chapter 4 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

## SECTION 10 Programs on drug safety and managing medications

### Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

## Section 10.2 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take many drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. The program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You will get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You will also get a personal medication list that will include all the medications you are taking and why you take them.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about this program, please contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

It is a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

# CHAPTER 4

## *What you pay for your Part D prescription drugs*

# Chapter 4. What you pay for your Part D prescription drugs

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### Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

### Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or "LIS Rider"), which tells you about your drug coverage. If you get Extra Help and did not receive this insert, please call CVS/caremark Customer Care and ask for the "LIS Rider." (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)

## SECTION 1 Introduction

### Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Original Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

As a member of PERS Select Medicare Part D PDP sponsored by CalPERS, some excluded drugs may be covered since your plan has supplemental drug coverage.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you under the Medicare part D portion of this plan.
  - It also tells which of the three "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet). You can also find the Drug List on our website at www.caremark.com/calpers. The Drug List on the website is always the most current.

- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan and which drugs may be covered under CalPERS supplemental coverage.
- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you how you can use the plan's mail-order service to get certain types of drugs. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three months' supply).

### Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered drugs. The amount that you pay for a drug is called "cost sharing," and there are two ways you may be asked to pay.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

## SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

### Section 2.1 What are the drug payment stages for PERS Select Medicare Part D PDP members?

As shown in the following table, there are "drug payment stages" for your prescription drug coverage under PERS Select Medicare Part D PDP. How much you pay for a drug depends on your benefit plan.

| **Stage 1**<br>*Initial Coverage Stage* | **Stage 2**<br>*Coverage Gap Stage* | **Stage 3**<br>*Catastrophic Coverage Stage* |
|---|---|---|
| You begin in this payment stage when you fill your first prescription of the year.<br>During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**<br>You stay in the Initial Coverage Stage until your year-to-date "**total drug costs**" (your payments plus any Part D plan's payments) total $3,310.00.<br>Payments you make for non-Part D drugs are not included in your "total drug costs."<br>(Details are in Section 5 of this chapter.) | CalPERS provides supplemental prescription drug coverage for you during the Coverage Gap Stage. The plan continues to cover your drugs at the applicable copayment until you qualify for the Catastrophic Coverage Stage.<br>You will stay in the Coverage Gap Stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,850.00.<br>Payments you make for non-Part D drugs are not included in your "total drug costs."<br>(Details are in Section 6 of this chapter.) | During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year (through December 31, 2016).<br>(Details are in Section 7 of this chapter.) |

As shown in this summary of the payment stages, whether you move on to the next payment stage depends on how much **you and the plan spend** for your drugs while you are in each stage.

## SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

### Section 3.1 We send you a monthly report called the "*Part D Explanation of Benefits*" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1, 2016.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Any supplemental drug coverage you receive from your employer group will not show up on your *Explanation of Benefits*.**

## Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 in this booklet .) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at a pharmacy and have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (EOB) in the mail, please look it over to be sure the information is complete and

correct. If you think something is missing from the report, or you have any questions, please call us at CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

## SECTION 4 There is no deductible for PERS Select Medicare Part D PDP

### Section 4.1 You do not pay a deductible for your Part D drugs

There is no deductible for PERS Select Medicare Part D PDP. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See the next section for information about your coverage in the Initial Coverage Stage.

## SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

### Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

#### The plan has three Cost-Sharing Tiers

Every drug on the plan's Drug List is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

- **Cost-Sharing Tier 1: Generic Drugs (lowest cost-sharing tier)**
- **Cost-Sharing Tier 2: Preferred Brand Drugs**
- **Cost-Sharing Tier 3: Non-Preferred Brand Drugs**

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

#### Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy
- A preferred retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network

- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and the plan's *Pharmacy Directory.*

Generally, we will cover your prescriptions *only* if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost sharing. You may go to either network pharmacies that offer preferred cost sharing or other network pharmacies that offer standard cost sharing to receive your covered prescription drugs. Your cost may be less at pharmacies that offer preferred cost sharing.

## Section 5.2 A table that shows your costs for a supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the following table, the amount of the copayment or coinsurance depends on which tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug or the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy. If you go to an out-of-network pharmacy, you must submit a paper claim form to us.

**Your share of the cost when you get a supply of a covered Part D prescription drug from:**

| Before your $1,000 Maximum Out-of-Pocket is met, your cost-sharing amounts will be: | | |
|---|---|---|
| | **Network Pharmacies and Preferred Network Pharmacies** | **Non-Network Pharmacies** |
| **Tier 1: Generic Drugs (lowest cost-sharing tier)** | *You pay $5.00 per prescription. (Up to a 30-day supply)* | *You pay the full cost per prescription.* |
| **Tier 2: Preferred Brand Drugs** | *You pay $20.00 per prescription. (Up to a 30-day supply)* | *You pay the full cost per prescription.* |
| **Tier 3: Non-Preferred Brand Drugs** | *You pay $50.00 per prescription. (Up to a 30-day supply)* | *You pay the full cost per prescription.* |
| **Erectile or Sexual Dysfunction Drugs** | *You pay 50% per prescription. (Quantity Limits apply)* | *You pay the full cost per prescription.* |

## Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per

day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- For example[2]: If the copay for your drug for a full month's supply (a 30-day supply) is $30.00. This means that the amount you pay per day for your drug is $1.00. If you receive a 7 days' supply of the drug, your payment will be $1.00 per day multiplied by 7 days, for a total payment of $7.00.

[2]Dollar amounts used in this example are for illustrative purposes only and do not reflect your actual copayments.

Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill date for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

## Section 5.4 A table that shows your costs for a *long-term* supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3, Section 2.4.)

The following table shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug *or* the copayment amount, *whichever is lower.*

**Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:**

| Before your $1,000 Maximum Out-of-Pocket is met, your cost-sharing amounts will be: | | | |
|---|---|---|---|
| | **Network Pharmacies** | **Preferred Network Pharmacies** | **CVS/caremark Mail Service Pharmacy** |
| **Tier 1: Generic Drugs (lowest cost-sharing tier)** | *You pay $5.00 per 30 day prescription. You pay $10.00 per 60 day prescription. You pay $15.00 per 90 day prescription.* | *You pay $10 per 90 day prescription.* *(Up to a 90-day supply)* | *You pay $10 per 90 day prescription.* *(Up to a 90-day supply)* |
| **Tier 2: Preferred Brand Drugs** | *You pay $20.00 per 30 day prescription. You pay $40.00 per 60 day prescription. You pay $60.00 per 90 day prescription.* | *You pay $40 per 90 day prescription.* *(Up to a 90-day supply)* | *You pay $40 per 90 day prescription.* *(Up to a 90-day supply)* |
| **Tier 3: Non-Preferred Brand Drugs** | *You pay $50.00 per 30 day prescription. You pay $100.00 per 60 day prescription. You pay $150.00 per 90 day prescription.* | *You pay $100 per 90 day prescription.* *(Up to a 90-day supply)* | *You pay $100 per 90 day prescription.* *(Up to a 90-day supply)* |
| **Erectile or Sexual Dysfunction Drugs** | *You pay 50% per prescription. (Quantity Limits apply)* | *You pay 50% per prescription. (Quantity Limits apply)* | *You pay 50% per prescription. (Quantity Limits apply)* |

## Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $3,310.00

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$3,310.00 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 5.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:

  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2016, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

PERS Select Medicare Part D PDP offers additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. To find out which drugs our plan covers, please call CVS/caremark Customer Care. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent for your drugs during the year. Many people do not reach the $3,310.00 limit in a year.

We will let you know if you reach this $3,310.00 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

## SECTION 6 During the Coverage Gap Stage, the plan provides some drug coverage

### Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,850.00

CalPERS provides supplemental prescription drug coverage for you during the Coverage Gap phase. The plan continues to cover your drugs at the applicable copayment until you qualify for the Catastrophic Stage. For more information, please refer to your Supplement to Original Medicare Plan *Evidence of Coverage* booklet, or call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

## Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

### These payments are included in your out-of-pocket costs

*When you add up your out-of-pocket costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this plan year under another Medicare Prescription Drug Plan before you joined our plan.

**It matters who pays:**

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by the Indian Health Service, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by Medicare's Extra Help and the Medicare Coverage Gap Discount Program are also included.

**Moving on to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of $4,850.00 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

### These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under your employer's supplemental coverage, but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans, including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

*Reminder:* If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call CVS/caremark Customer Care to let us know (phone numbers are printed on the last page of this booklet).

### *How can you keep track of your out-of-pocket total?*

- **We will help you**. The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $4,850.00 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

## SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

### Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your true out-of-pocket costs have reached the $4,850.00 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.

During this stage, the plan will pay most of the cost for your drugs.

**Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *lower amount*:

- *either* coinsurance of 5% of the cost of the drug
- *or* your applicable drug tier copayment

Medicare has rules about what counts and what does not count as your out-of-pocket costs. Your *Evidence of Coverage* and *Explanation of Benefits* will provide more detail on your annual drug costs and out-of-pocket costs.

## SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

### Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage of a number of Part D vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

#### What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).

- Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*.
- Other vaccines are considered medical benefits. They are covered under Original Medicare.

2. **Where you get the vaccine.**

3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember, you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

*Situation 1:* You buy the vaccine at the pharmacy and you get your Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

*Situation 2:* You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet (*Asking the plan to pay its share of the costs for covered drugs*).
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

*Situation 3:* You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

### Section 8.2 You may want to call us at CVS/caremark Customer Care before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at CVS/caremark Customer Care whenever you are planning to get a vaccination. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

## SECTION 9 Do you have to pay the Part D "Late Enrollment Penalty"?

### Section 9.1 What is the Part D "Late Enrollment Penalty"?

**Note:** If you receive Extra Help from Medicare to pay for your prescription drugs, you will not pay a Late Enrollment Penalty.

You may owe a Late Enrollment Penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable

prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

If you are required to pay a Late Enrollment Penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 4 explains the Late Enrollment Penalty.

If you have a Late Enrollment Penalty, it is part of your plan premium. If you do not pay the part of your premium that is the Late Enrollment Penalty, you could be disenrolled for failure to pay your plan premium. Therefore, to avoid disenrollment, make sure your Late Enrollment Penalty is paid.

If you have a Late Enrollment Penalty, you will receive a monthly invoice from PERS Select Medicare Part D PDP. If you do not pay the monthly Late Enrollment Penalty premium, you could be disenrolled for failure to pay your plan premium. Therefore, to avoid disenrollment, make sure your Late Enrollment Penalty is paid.

## Section 9.2 How much is the Part D Late Enrollment Penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or, count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
    - For example, if you decide to wait 14 months before you join a Medicare Part D plan. That would mean you have 14 months without coverage. You multiply your total uncovered months by the 1% monthly penalty without coverage. Your total monthly Late Enrollment Penalty would be 14% of the previous year's average monthly Medicare Part D premium.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2015, this average premium amount is $33.13. This amount may change for 2016.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $33.13, which equals $4.64. This rounds to $4.60. This amount would be added **to the monthly premium for someone with a Late Enrollment Penalty.**

There are three important things to note about this monthly Late Enrollment Penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.

- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the Late Enrollment Penalty will reset when you turn 65. After age 65, your Late Enrollment Penalty will be based only on the months that you do not have coverage after your initial enrollment period for aging into Medicare.

## Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Late Enrollment Penalty.

**You will not have to pay a penalty for late enrollment if you are in any of these situations:**

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this **"creditable drug coverage."**
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2016* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving Extra Help from Medicare.

### Section 9.4 What can you do if you disagree about your Late Enrollment Penalty?

If you disagree about your Late Enrollment Penalty, you or your representative can ask for a review of the decision about your Late Enrollment Penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a Late Enrollment Penalty. Call CVS/caremark Customer Care to find out more about how to do this (phone numbers are printed on the last page of this booklet).

**Important:** Do not stop paying your Late Enrollment Penalty while you are waiting for a review of the decision about your Late Enrollment Penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

## SECTION 10 Do you have to pay an extra Part D amount because of your income?

### Section 10.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is greater than $85,000 for an individual (or married individuals filing separately), or greater than $170,000 for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit is not enough to cover the extra amount owed. If your benefit check is not enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the Social Security Administration. It cannot be paid with your monthly plan premium.**

### Section 10.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

| If you filed an individual tax return and your income in 2014 was: | If you were married, but filed a separate tax return and your income in 2014 was: | If you filed a joint tax return and your income in 2014 was: | This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium) |
|---|---|---|---|
| Equal to or less than $85,000.00 | Equal to or less than $85,000.00 | Equal to or less than $170,000.00 | $0 |
| Greater than $85,000.00 and less than or equal to $107,000.00 | | Greater than $170,000.00 and less than or equal to $214,000.00 | $12.30 |
| Greater than $107,000.00 and less than or equal to $160,000.00 | | Greater than $214,000.00 and less than or equal to $320,000.00 | $31.80 |
| Greater than $160,000.00 and less than or equal to $214,000.00 | Greater than $85,000.00 and less than or equal to $129,000.00 | Greater than $320,000.00 and less than or equal to $428,000.00 | $51.30 |
| Greater than $214,000.00 | Greater than $129,000.00 | Greater than $428,000.00 | $70.80 |

## Section 10.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213, 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778.

## Section 10.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

# CHAPTER 5

## *Asking the plan to pay its share of the costs for covered drugs*

# Chapter 5. Asking the plan to pay its share of the costs for covered drugs

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# SECTION 1 Situations in which you should ask the plan to pay its share of the cost of your covered drugs

## Section 1.1 If you pay the plan's share of the cost of your covered drugs, you can ask PERS Select Medicare Part D PDP for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

### 1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Section 2.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.
- If you use an out-of-network pharmacy, we will reimburse you our network contracted rate minus your cost-share amount for the drug. You must submit a paper claim in order to be reimbursed.

**Your prescription may be covered in certain situations**

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out of stock at an accessible network retail or mail service pharmacy (including high-cost and unique drugs).
- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.

If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more than you would have paid if you had gone to an in-network pharmacy.

In these situations, please check first with CVS/caremark Customer Care to see if there is a network pharmacy nearby. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)

### 2. When you pay the full cost for a prescription because you do not have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

### 3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

### 4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call CVS/caremark Customer Care for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)
- Ensure you provide this information no later than three (3) years from the date of service. Claims submitted after that date may not be processed. If you need to request

an appeal on your denied paper claim, you must submit that request (with any representative forms) within 60 days from the date of the notice of the coverage determination (i.e., the date printed or written on the notice).

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint [coverage decisions, appeals, complaints]*) has information about how to make an appeal.

## SECTION 2 How to ask PERS Select Medicare Part D PDP to pay you back

### Section 2.1 How and where to send PERS Select Medicare Part D PDP your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It is a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You do not have to use the form, but it is helpful for our plan to process the information faster.
- Either download a copy of the form from our website www.caremark.com/calpers) or call CVS/caremark Customer Care and ask for the form. (Phone numbers are printed on the last page of this booklet.)

Mail your request for payment together with any receipts to us at this address:

Medicare Part D Paper Claims
P.O. Box 52066
Phoenix, AZ 85072-2066

**You must submit your claim to us within three (3) years** of the date you received the service, item, or drug.

Contact CVS/caremark Customer Care if you have any questions (phone numbers are printed on the last page of this booklet). If you do not know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

## SECTION 3 The plan will consider your request for payment and say yes or no

### Section 3.1 The plan will check to see whether PERS Select Medicare Part D PDP should cover the drug and how much PERS Select Medicare Part D PDP owes

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

### Section 3.2 If the plan tells you that PERS Select Medicare Part D PDP will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment, or you do not agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint [coverage decisions, appeals, complaints]*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Chapter 7, Section 4. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after reading Section 4, you can go to Chapter 7, Section 5.5 for a step-by-step explanation of how to file an appeal.

## SECTION 4 Other situations in which you should save your receipts and send copies to the plan

### Section 4.1 In some cases, you should send copies of your receipts to the plan to help track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

**1. When you buy the drug for a price that is lower than our price**

Sometimes when you are in the Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or, you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

**2. When you get a drug through a patient assistance program offered by a drug manufacturer**

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs, but sending a copy of the receipt allows us to calculate your out-of-pocket

costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

# CHAPTER 6

## *Your rights and responsibilities*

# Chapter 6. Your rights and responsibilities

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## SECTION 1 Our plan must honor your rights as a member of the plan

### Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you. To get information from us in a way that works for you, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users should call 1-877-486- 2048.

### Sección 1.1 Debemos proporcionar información de una manera que le sea útil a usted (en otros idiomas además de inglés, en Braille, en impresión ampliada, en otros formatos alternativos, etc.)

Si desea que le enviemos información de manera que le resulte útil, por favor, llame a Cuidado al Cliente CVS/caremark (los números de teléfono están impresos en la parte de atrás de este manual).

Nuestro plan cuenta con personal y servicios de intérprete de idiomas gratis disponibles para responder las preguntas de los miembros que no hablan inglés. También podemos darle la información en Braille, en texto con letras grandes o en otros formatos alternativos que pueda necesitar. Si es elegible para Medicare por una incapacidad, debemos proporcionarle la información sobre los beneficios del plan de una manera accesible y adecuada para usted. Si desea que le enviemos información de manera que le resulte útil, por favor, llame a Cuidado al Cliente CVS/caremark (los números de teléfono están impresos en la parte de atrás de este manual).

Si tiene algún problema para recibir información de nuestro plan debido a problemas relacionados con el idioma o su incapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana, e informe que desea presentar una queja. Los usuarios de TTY pueden comunicarse al 1-877-486-2048.

## Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY: 1-800-537-7697), or call your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet). If you have a complaint, such as a problem with wheelchair access, CVS/caremark Customer Care can help.

## Section 1.3 We must ensure that you get timely access to your covered drugs

As a member of our plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you do not agree with our decision, Chapter 7, Section 4 tells what you can do.)

## Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan, as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

### How do we protect the privacy of your health information?

- We make sure that unauthorized people do not see or change your records.
- In most situations, if we give your health information to anyone who is not providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

### You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Effective September 2013**

### 1. OUR PRIVACY PRACTICES

CVS/caremark is committed to protecting the privacy and confidentiality of your personal information in accordance with law and our own company policies. This notice describes our privacy practices for both current and former enrollees. It explains how we use health information about you and when we may share that health information with others. It also informs you about your rights with respect to your health information and how you may exercise these rights. We are required by law to maintain the privacy of your health information and to provide you a copy of this notice of our legal duties and privacy practices regarding your health information so that you are aware of how we maintain the privacy of your health information. We are also required to notify affected individuals in the event there is a breach of their unsecured health information.

When we refer to "health information" in this notice, we mean financial, health, and other information about you that is non-public and that we obtain so that we can provide you with health insurance coverage. It includes demographic information, and other information that may identify you and that relates to your past, present, or future physical or mental health and related health care services.

Our workforce is required to comply with our policies and procedures to protect the confidentiality of health information, and will be subject to a disciplinary process if they violate these policies and procedures. We maintain physical, electronic, and process safeguards to protect against unauthorized access to your health information, and authorized access is on a "need-to-know" basis only.

## 2. HEALTH CARE INFORMATION MAINTAINED AT CVS/CAREMARK

We obtain information from a variety of sources, not all of which apply to every enrollee. The following reflects the general categories of information we collect:

- Information provided on enrollment forms, surveys, and our website, such as your name, address, and date of birth;
- Information from pharmacies, physicians or other health care providers, long-term care facilities, or health plans;
- Information provided by your employer or other plan sponsor regarding any group plan that you may have;
- Information we obtain from your transactions with us, our affiliates, or others, such as health care providers;
- Information we receive from consumer or medical reporting agencies or others, such as state regulators and law enforcement agencies

## 3. HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The following categories describe how we may use and disclose your health information.

**For Treatment**
We may use and disclose your health information to your pharmacy, doctors, or other health care providers to help them provide medical care to you. For example, we may provide information about other medications you are taking to a pharmacist filling your prescription so as to avoid harmful drug interactions. We may also share your health information with health care providers to help coordinate and manage your health care. For example, we may talk to your doctor to suggest a medication therapy management program that can help improve your health.

**For Payment**
We may use and disclose your health information to determine your eligibility for coverage and benefits, and to see that the treatment and services you receive are properly billed and paid for. For example, we may use your health information to pay the pharmacies that fill your prescriptions. Other payment activities include claims management, drug utilization review, and

other related administrative functions. We are prohibited from using or disclosing any genetic information about you for underwriting purposes.

**For Health Care Operations**
We may use and disclose certain health information to conduct our health care operations. Examples of health care operations include: performing quality assessment and improvement activities, and evaluating provider and health plan performance; performing auditing functions, fraud and abuse detection and compliance activities, resolving internal grievances, and addressing problems or complaints; and making benefit determinations, administering a benefit plan, and providing customer care.

**To Make Health-Related Communications to You**
We may use and disclose your health information in order to inform you about health-related products and services. For example, we may contact you:

- To remind you to refill your prescription or otherwise follow your drug therapy regimen.
- To tell you about possible treatment options or medication alternatives that may be beneficial to you.
- To tell you about health-related program benefits and services that may be of interest to you.

**To CalPERS**
Under certain circumstances, we may share limited health information about you with CalPERS, the sponsor of the group health plan through which you receive health benefits. For example, we may share information with CalPERS related to your enrollment or disenrollment in the plan, as well as summary health information to enable CalPERS to obtain bids from other health plans. We may also share information for plan administration purposes if certain protections are included in the plan document.

**For the Treatment, Payment, and Health Care Operations of Other Health Plans or Health Care Providers**
We may disclose your health information for another health plan or health care provider's treatment, payment, and, if certain conditions are met, health care operations. For example, we may disclose your health information when it would facilitate payment for services under another health plan.

**OTHER USES AND DISCLOSURES**
We may also make the following types of uses and disclosure of your health information:

- To a friend or family member who is involved in your care or to someone who helps pay for your care if you are not present or do not object, and we believe it is in your best interests in the circumstances. This includes disclosure to an entity assisting in a disaster relief effort so that your family or those involved in your care can be notified about your condition, status, or location.
- To entities performing any business functions for us, provided the entity agrees to protect and safeguard your health information, and to use and disclose it only as permitted by us.

- To conduct medical research, provided that additional measures are taken to protect your privacy.
- To comply with state and federal laws that require the release of your health information.
- To public health authorities or others acting under their authority for purposes such as reporting adverse reactions to medications or problems with medical products, or if we believe there is a serious threat to your health and safety or that of others.
- To health oversight agencies for activities such as audits, inspections, licensure, and peer review activities.
- For legal or administrative proceedings, such as pursuant to a court order, search warrant, or subpoena.
- To support law enforcement activities; for example, we may provide health information to law enforcement agents for the purpose of identifying or locating a fugitive, material witness, or missing person.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- To report information to a government authority regarding child abuse, neglect, or domestic violence.
- To share information with a coroner or medical examiner as authorized by law, or with funeral directors, as necessary to carry out their duties.
- To use or share information for procurement, banking, or transplantation of organs, eyes, or tissues.
- To report information regarding job-related injuries as required by your state worker compensation laws.
- To share information related to specialized government functions, such as military and veteran activities, national security and intelligence activities and protective services for the President and others.

### 4. USES AND DISCLOSURES REQUIRING WRITTEN AUTHORIZATION

Your written authorization is required for the following types of uses and disclosures of your health information:

- Most uses and disclosures of psychotherapy notes (if applicable).
- Uses and disclosures for marketing purposes, except for face-to-face communications and the provision of promotional gifts of nominal value. If we will receive payment for making such a marketing communication, the authorization is required to state this.
- Uses and disclosures that qualify as a sale of health information. If we will receive direct or indirect payment in exchange for your health information, the authorization is required to state this.

In addition to the above, any other uses and disclosures of your health information not described elsewhere in this notice will be made only with your prior written authorization. If you provide a written authorization and you change your mind, you may revoke your authorization in writing at any time. Once an authorization has been revoked, we will no longer use or disclose the health information as outlined in the authorization; however, you should be aware that we will not be able to retract a use or disclosure that was previously made based on a valid authorization.

## 5. YOUR HEALTH INFORMATION RIGHTS

You have certain rights regarding health information we maintain about you as described below. To exercise any of these rights, you must send a request in writing, with any additional information required, to: CalPERS C/O CVS/caremark - ATTN: Privacy Officer, P.O. BOX 52072, MC 016, Phoenix, AZ 85072-2072. Please include your card identification number on your written correspondence.

1. Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you. You may also ask us to provide a copy of your health information to another person. In that case, your written request must be signed by you, must clearly identify the person to whom the copy of your health information is to be sent, and must state where the copy is to be sent. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or, if you agree to receive a summary or explanation of the information, the cost of preparing the summary or explanation. We may deny your request in certain circumstances. If your request is denied, you may ask that we review the denial.
2. Right to Amend. If you believe that health information we maintain about you is inaccurate or incomplete, you may ask us to amend it. In your request, you must include a reason that supports the amendment you request. If we did not create the information, you must explain why you believe the person who created it is no longer available to amend it. We may deny your request in certain circumstances. If so, you may submit a statement disagreeing with the denial, which will be appended or linked to the information in question.
3. Right to an Accounting of Disclosures. You have the right to receive a list of certain non-routine disclosures we make of health information about you. In your request for an accounting, you must specify the time period for which you want the accounting. The first list you request in any 12 month period will be free of charge; thereafter, we may charge a fee to cover the costs of providing this information to you.
4. Right to Request Restrictions. You have the right to request a restriction on how we use or disclose health information about you for treatment, payment, or health care operations. You also have the right to request a restriction on disclosures to someone involved in your care or the payment of your care, like a family member. If you request a restriction, you must specify what information you want restricted and in what way. We are not required to agree to a requested restriction.
5. Right to Request Confidential Communications. You have the right to request that we send communications involving health information about you by a certain method of communication or to a certain address if you believe that disclosure of some or all of your

health information could endanger you. If you request a confidential communication, your request must include a statement that the disclosure of your health information could endanger you, and must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

6. Right to Paper Copy of this Notice. You have the right to obtain a paper copy of this notice at any time by writing to the address provided below, even if you have previously agreed to receive it electronically. You may also view a copy of this notice on our website at www.caremark.com/calpers.

## 6. STATE LAW

In some situations, state privacy or other applicable laws may provide greater privacy protections than those stated in this notice. For example, depending on the state in which you reside, there may be additional laws related to the use and disclosure of health information related to HIV status, communicable diseases, reproductive health, genetic test results, substance abuse, mental health, and mental retardation. When appropriate, we will follow those state or other applicable laws.

## 7. CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the changes effective for health information about you that we already have, as well as for any health information we obtain or create in the future.

We will retain health information about you even after your insurance coverage with us terminates, since it may be necessary to use and disclose it for the reasons described above. However, we will have in place policies and procedures to continue to protect the information. We will post a copy of our most current notice on our website at www.caremark.com/calpers. The effective date of the notice will be on the first page. In addition, paper copies of the most current notice may be obtained by sending a written request to CalPERS C/O CVS/caremark - ATTN: Privacy Officer, P.O. BOX 52072, MC 016, Phoenix, AZ 85072-2072.

## 8. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, you must send it in writing to CalPERS C/O CVS/caremark - ATTN: Privacy Officer, P.O. BOX 52072, MC 016, Phoenix, AZ 85072-2072. We will not retaliate against you in any way for filing a complaint and the service you receive from us will be unaffected.

## 9. CONTACT INFORMATION

If you have any questions about this notice, please contact us at:

CalPERS C/O CVS/caremark – Attn: Privacy Officer
P.O. BOX 52072, MC 016
Phoenix, AZ 85072-2072

## Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of PERS Select Medicare Part D PDP, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English, Braille, in large print or audio formats.)

Esta información está disponible en un formato diferente, incluyendo en español, en letras grandes, en Braille y en cinta de audio. Llame a la oficina de Servicio al Cliente a los números indicados arriba si necesita información sobre el plan en otro formato o en otro idioma.

If you want any of the following kinds of information, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Prescription Drug Plans.
- **Information about our network pharmacies.**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory.*
  - For more detailed information about our pharmacies, you can call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet) or visit our website at www.caremark.com/calpers.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - CalPERS is providing supplemental coverage and may cover drugs not covered under Part D. Please contact CVS/caremark Customer Care for a list of the covered exclusions.
  - If you have questions about the rules or restrictions, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

- **Information about why something is not covered and what you can do about it.**
  - If a Part D drug is not covered for you or is not covered under CalPERS supplemental coverage, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
    - If a Part D drug is not covered for you, or if your coverage is restricted in some way, the decision must be based only on the appropriateness of care and your current Part D prescription drug coverage. We may not reward physicians or others for deciding not to cover a Part D drug. We may not offer financial incentives to encourage decisions that deny coverage.
  - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you or about what drug is covered for you unders CalPERS supplemental coverage, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

## Section 1.6 We must support your right to make decisions about your care

### You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact CVS/caremark Customer Care to ask for the forms (phone numbers are printed on the last page of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you cannot. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

**Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

### What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate State licensing board. Your State Department of Health may be able to help you find the appropriate agency. Please call CVS/caremark Customer Care for contact information of the State Medical Assistance Office in your state. (CVS/caremark Customer Care phone numbers are printed on the last page of this booklet.)

## Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

## Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

### If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019. (TTY: 1-800-537-7697), or call your local Office for Civil Rights.

### Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it is *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call CVS/caremark Customer Care** (phone numbers are printed on the last page of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call CVS/caremark Customer Care** (phone numbers are printed on the last page of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

# SECTION 2 You have some responsibilities as a member of the plan

## Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet). We're here to help.

- ***Get familiar with your covered drugs and the rules you must follow to get these covered drugs.*** *Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.*
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs and drugs covered by CalPERS supplemental coverage.
- ***If you have any other prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call CVS/caremark Customer Care to let us know (phone numbers are printed on the last page of this booklet).*
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your plan membership card whenever you get your Part D prescription drugs.*
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements (including herbal supplements).
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you do not understand the answer you are given, ask again.
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
  - You, or CalPERS, must pay your plan premiums to continue being a member of our plan.
  - For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance

(a percentage of the total cost). Chapter 4 tells what you must pay for your Part D prescription drugs.

- If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for more information about how to make an appeal.
- If you are required to pay a Late Enrollment Penalty, you must pay the penalty to remain a member of our plan.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- ***Tell us if you move.*** *If you are going to move, it is important to tell us right away. Call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).*
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - **When moving, you should always contact CalPERS and update your address.**
  - If you move, it is also important to tell the Social Security Administration (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- ***Call CVS/caremark Customer Care for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
  - Phone numbers and calling hours for CVS/caremark Customer Care are printed on the last page of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

# CHAPTER 7

## *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*

# Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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# BACKGROUND

## SECTION 1 Introduction

### Section 1.1 What to do if you have a problem or concern

The following section details your appeals rights for drugs covered by Medicare. Your appeals rights for drugs not covered by Medicare begins in Section 4. CVS/caremark will help you navigate the appropriate appeals process. If you have any questions, contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

### Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

## SECTION 2 You can get help from government organizations that are not connected with us

### Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

#### Get help from an independent government organization

We are always available to help you, but in some situations you may also want help or guidance from someone who is not connected to us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. Call CVS/caremark Customer Care for phone numbers of the SHIP in your local state. (CVS/caremark Customer Care phone numbers are printed on the last page of this booklet.)

#### You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

## SECTION 3 To deal with your problem, which process should you use?

### Section 3.1 Should you use the process for coverage decisions and appeals? Or, should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

**Is your problem or concern about your benefits or coverage?**

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

**Yes.** My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

**No.** My problem is not about benefits or coverage.

Skip ahead to **Section 7** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

# COVERAGE DECISIONS AND APPEALS

## SECTION 4 A guide to the basics of coverage decisions and appeals

### Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for Part D prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

The coverage request rules and appeals process for drugs covered through your CalPERS supplemental coverage can be found in Chapter 9. You can contact CVS/caremark Customer Care for any questions regarding your supplemental benefit.

#### Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

### Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

## Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at CVS/caremark Customer Care** (phone numbers are printed on the last page of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other prescriber can make a request for you.** Your doctor or other prescriber can request a coverage decision or a Level 1 or a Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet) and ask for the "Appointment of

Representative" form. (The form is also available on Medicare's website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.caremark.com/calpers.) The form gives that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

## SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

**Have you read Section 4 of this chapter (*A guide to the basics of coverage decisions and appeals*)? If not, you may want to read it before you start this section.**

### Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary).* To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. The appeals process for drugs covered through your supplemental coverage can be found in your Supplement to Original Medicare Plan booklet.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 3 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 4 (*What you pay for your Part D prescription drugs*).

## Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

| Legal Terms |
| --- |
| An initial coverage decision about your Part D drugs is called a **"coverage determination."** |

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug, if applicable to your plan
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary),* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

### Which of these situations are you in?

| If you are in this situation: | This is what you can do: |
|---|---|
| Do you need a drug that is not on our Drug List or need us to waive a rule or restriction on a drug we cover? | You can ask us to make an exception. (This is a type of coverage decision.)<br><br>Start with **Section 5.2** of this chapter. |
| Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? | You can ask us for a coverage decision.<br><br>Skip ahead to **Section 5.4** of this chapter. |
| Do you want to ask us to pay you back for a drug you have already received and paid for? | You can ask us to pay you back. (This is a type of coverage decision.)<br><br>Skip ahead to **Section 5.4** of this chapter. |
| Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? | You can make an appeal. (This means you are asking us to reconsider.)<br><br>Skip ahead to **Section 5.5** of this chapter. |

## Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are multiple examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

| Legal Terms |
|---|
| Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."** |

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in the Preferred Brand tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 3).

| Legal Terms |
| --- |
| Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."** |

- The extra rules and restrictions on coverage for certain drugs include:
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *For plans with Step Therapy, being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - *For plans with Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier,** if applicable to your plan**.** Every drug on our Drug List is in one of multiple cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

| Legal Terms |
| --- |
| Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."** |

- If your drug is in the Non-Preferred Brand tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand tier instead. This would lower the amount you must pay for your drug.

## Section 5.3 Important things to know about asking for exceptions

### Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting, and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

### We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

## Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

**Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.**

***What to do***

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact the plan when you are asking for a coverage decision or making an appeal about your Part D prescription drugs*. Or, if you are asking us to pay you back for a drug, go to the section called, *Where to send a request asking us to pay for our share of the cost for a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading Chapter 5 of this booklet: *Asking the plan to pay its share of the costs for covered drugs.* Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or, your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

### *If your health requires it, ask us to give you a "fast coverage decision"*

| Legal Terms |
| --- |
| A "fast coverage decision" is called an **"expedited coverage determination."** |

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a "fast coverage decision" on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.

- The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

**Step 2: We consider your request and we give you our answer.**

***Deadlines for a "fast coverage decision"***

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

***Deadlines for a "standard coverage decision" about a drug you have not yet received***

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

***Deadlines for a "standard coverage decision" about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Step 3: If we say no to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

| Section 5.5 | Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan) |
|---|---|

| Legal Terms |
|---|
| An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."** |

**Step 1: You contact us and make your Level 1 Appeal.** If your health requires a quick response, you must ask for a **"fast appeal."**

***What to do***

- **To start your appeal, you, your representative, your doctor, or other prescriber must contact us.**

  - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact the plan when you are asking for a coverage decision or making an appeal about your Part D prescription drugs.*

- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact the plan when you are asking for a coverage decision or making an appeal about your Part D prescription drugs*).
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *(How to contact the plan when you are asking for a coverage decision or making an appeal about your part D prescription drugs)*.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website, www.caremark.com/calpers.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

### *If your health requires it, ask for a "fast appeal"*

| Legal Terms |
| --- |
| A "fast appeal" is also called an **"expedited redetermination."** |

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.4 of this chapter.

## Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

### *Deadlines for a "fast appeal"*

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

### *Deadlines for a "standard appeal"*

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 14 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

### Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

## Section 5.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

| Legal Terms |
| --- |
| The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."** |

### Step 1: To make a Level 2 Appeal, you, your representative, your doctor, or other prescriber must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

### Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

### *Deadlines for "fast appeal" at Level 2*

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

### *Deadlines for "standard appeal" at Level 2*

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

## What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the prescription drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

**Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## SECTION 6 Taking your appeal to Level 3 and beyond

### Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

| | |
|---|---|
| **Level 3 Appeal** | **A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge." |

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

| | |
|---|---|
| **Level 4 Appeal** | The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government. |

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact, and what to do next, if you choose to continue with your appeal.

| | |
|---|---|
| **Level 5 Appeal** | A judge at the **Federal District Court** will review your appeal. |

- This is the last step of the appeals process for Part D drugs.

**You have specific coverage request rules and appeal rights for drugs covered by your CalPERS supplemental coverage. These rules and rights can be found in Chapter 9.**

# MAKING COMPLAINTS

## SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns

**If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.**

### Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

### If you have any of these kinds of problems, you can "make a complaint":

| Complaint | Example |
|---|---|
| **Quality of your medical care** | • Are you unhappy with the quality of the care you have received? |
| **Respecting your privacy** | • Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential? |
| **Disrespect, poor customer service, or other negative behaviors** | • Has someone been rude or disrespectful to you?<br>• Are you unhappy with how our CVS/caremark Customer Care has treated you?<br>• Do you feel you are being encouraged to leave the plan? |
| **Waiting times** | • Have you been kept waiting too long by pharmacists? Or by our CVS/caremark Customer Care or other staff at the plan?<br>  ○ Examples include waiting too long on the phone or when getting a prescription. |
| **Cleanliness** | • Are you unhappy with the cleanliness or condition of a pharmacy? |
| **Information you get from us** | • Do you believe we have not given you a notice that we are required to give?<br>• Do you think written information we have given you is hard to understand? |

| Complaint | Example |
|---|---|
| **Timeliness**<br>(These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals.) | The process of asking for a coverage decision and making appeals is explained in Sections 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.<br>However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:<br>• If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.<br>• If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.<br>• When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.<br>• When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint. |

## Section 7.2 The formal name for "making a complaint" is "filing a grievance"

**Legal Terms**

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**

Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

## Section 7.3 Step-by-step: Making a complaint

### Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling CVS/caremark Customer Care is the first step.** If there is anything else you need to do, CVS/caremark Customer Care will let you know. Call 1-855-479-3660, 24 hours a day. 7 days a week. TTY users should call 711.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **You may submit a grievance via fax at 1-866-217-3353. Or you may send it to us in writing to:**

  CVS/caremark
  Prescription Drug Plans
  Grievance Department
  P.O. Box 53991, MC 121
  Phoenix, AZ 85072-3991

  Upon receipt of your complaint, we will initiate the Grievance process.

  - If you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing.
  - We must notify you of our decision about your complaint (grievance) as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- **In certain cases, you have the right to ask for a fast review of your complaint.** This is called the Expedited Grievance Process. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations.
  - We deny your request for a fast review of a request for drug benefits.
  - We deny your request for a fast review of an appeal of denied drug benefits.
    - You may submit this type of complaint by phone by calling CVS/caremark Customer Care at the number on the last page of this booklet.
- **For a fast complaint about a denial regarding your request for expedited coverage determinations or redeterminations, you may submit the complaint by calling CVS/caremark Customer Care.** We will contact you within 24 hours by phone to notify you of our response. This will also be followed up by a written response.

- **Whether you call or write, you should contact CVS/caremark Customer Care right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint**. If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

| Legal Terms |
| --- |
| What this section calls a **"fast complaint"** is also called an **"expedited grievance."** |

### Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or do not take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

## Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

## Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about PERS Select Medicare Part D PDP directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

# CHAPTER 8

## *Ending your membership in the plan*

# Chapter 8. Ending your membership in the plan

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# SECTION 1 Introduction

## Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in PERS Select Medicare Part D PDP may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

**Please note: This prescription coverage is offered in conjunction with your medical coverage. If you choose a Medicare Prescription Drug Plan other than PERS Select Medicare Part D PDP, you cannot be enrolled in the PERS Select Supplement to Original Medicare Plan and you will lose your CalPERS medical benefits.**

# SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the annual Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

## Section 2.1 Usually, you can end your membership during the annual Open Enrollment Period

You may end your membership during the annual **Open Enrollment Period**. This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the annual Open Enrollment Period?** This happens from September 14, 2015 to October 9, 2015. Please contact CalPERS for more information about your annual Open Enrollment Period.

- **What type of plan can you switch to during the annual Open Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare Prescription Drug Plan. If you choose to enroll in another Medicare Prescription Drug Plan that is not part of a CalPERS health plan, then you may not maintain enrollment in PERS Select Medicare Part D PDP.
  - Original Medicare *without* a separate Medicare Prescription Drug Plan. If you choose to enroll in original Medicare without a separate Medicare Prescription Drug Plan, you will be financially responsible for all of your medical and prescription drug coverage and you may not maintain enrollment in PERS Select Medicare Part D PDP.
  - A Medicare Health Plan. A Medicare Health Plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Health Plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare Health Plans (meaning a non-CalPERS health plan), you will be automatically disenrolled from PERS Select Medicare Part D PDP when your new plan's coverage begins. If you do not want to keep our plan, you can choose to enroll in another Medicare Prescription Drug Plan or drop Medicare prescription drug coverage.
  - **If you receive Extra Help from Medicare to pay for your prescription drugs.** If you do not enroll in a separate Medicare Prescription Drug Plan, Medicare may enroll you in a prescription drug plan, unless you have opted out of automatic enrollment.

  **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a Late Enrollment Penalty if you join a Medicare Prescription Drug Plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1, 2016.

## Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of PERS Select Medicare Part D PDP may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
    - If you have moved out of your plan's service area.
    - If you have Medicaid.
    - If you are eligible for Extra Help with paying for your Medicare prescriptions.
    - If we violate our contract with you.
    - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
    - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
    - Another Medicare Prescription Drug Plan. CalPERS members may only choose another CalPERS plan with Part D coverage. If they choose to enroll in a Part D plan that is not part of a CalPERS health plan, then they may not maintain enrollment in the CalPERS health plan.
    - Original Medicare *without* a separate Medicare Prescription Drug Plan.
        - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare Prescription Drug Plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment; or
    - A Medicare Health Plan. A Medicare Health Plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Health Plans also include Part D prescription drug coverage.
        - If you enroll in most Medicare Health Plans (meaning a non-CalPERS health plan), you will automatically be disenrolled from PERS Select Medicare Part D PDP when your new plan's coverage begins. If you do not want to keep our plan, you can choose to enroll in another

Medicare Prescription Drug Plan or to drop Medicare prescription drug coverage.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a Late Enrollment Penalty if you join a Medicare Prescription Drug Plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

### Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call CVS/caremark Customer Care** (phone numbers are printed on the last page of this booklet).
- You can find the information in the ***Medicare & You* 2016** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## SECTION 3 How do you end your membership in our plan?

### Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare Prescription Drug Plan during one of the enrollment periods (see Section 2 of this chapter for information about the enrollment periods). However, there is one situation in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare Prescription Drug Plan, you must ask to be disenrolled from our plan.

- This prescription drug coverage is offered in conjunction with your medical coverage. If you choose a Medicare Prescription Drug Plan other than PERS Select Medicare Part D PDP, you will lose your CalPERS medical benefits.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact CVS/caremark Customer Care if you need more information on how to do this (phone numbers are printed on the last page of this booklet); or
- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a Late Enrollment Penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 4, Section 9 for more information about the Late Enrollment Penalty.

**The table below explains how you should end your membership in our plan:**

| If you would like to switch from our plan to: | This is what you should do: |
|---|---|
| • Another Medicare Prescription Drug Plan. | • Enroll in the new Medicare Prescription Drug Plan.<br>You will automatically be disenrolled from PERS Select Medicare Part D PDP when your new plan's coverage begins. |
| • A Medicare Health Plan. | • Enroll in the Medicare Health Plan. With most Medicare Health Plans, you will automatically be disenrolled from PERS Select Medicare Part D PDP when your new plan's coverage begins.<br>• If you want to leave our plan, you must *either* enroll in another Medicare Prescription Drug Plan *or* ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet) if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. |
| • Original Medicare *without* a separate Medicare Prescription Drug Plan.<br>• **Note:** If you disenroll from a Medicare Prescription Drug Plan and go without creditable prescription drug coverage, you may need to pay a Late Enrollment Penalty if you join a Medicare Prescription Drug Drug Plan later. See Chapter 4, Section 9 for more information about the Late Enrollment Penalty. | • **Send us a written request to disenroll.** Contact CVS/caremark Customer Care if you need more information on how to do this (phone numbers are printed on the last page of this booklet).<br>• You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. |

## SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

### Section 4.1 Until your membership ends, you are still a member of our plan

If you leave PERS Select Medicare Part D PDP, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- If you use an out of network pharmacy, we will reimburse you our network contracted rate minus your cost-share amount for the drug. You must submit a paper claim in order to be reimbursed.

## SECTION 5 PERS Select Medicare Part D PDP must end your membership in the plan in certain situations

### Section 5.1 When must we end your membership in the plan?

**PERS Select Medicare Part D PDP must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you enroll in another Medicare Part D Plan.
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
    - If you move or take a long trip, you need to call CVS/caremark Customer Care to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for CVS/caremark Customer Care are printed on the last page of this booklet.)
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D Income Related Monthly Adjustment Amount (Part D–IRMAA) because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

### Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **CVS/caremark Customer Care** for more information (phone numbers are printed on the last page of this booklet).

## Section 5.2 We cannot ask you to leave our plan for any reason related to your health

**CalPERS** is not allowed to ask you to leave our plan for any reason related to your health.

### What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

## Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

# CHAPTER 9

## *CalPERS Supplemental Prescription Drug Coverage*

# Chapter 9. CalPERS Supplemental Prescription Drug Coverage

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## SECTION 1 Supplemental Prescription Drug Coverage Benefits

The Supplemental Prescription Drug Coverage is administered by CVS/caremark. This program will pay for non-Medicare Part D Prescription Medications which are: (a) prescribed by a Prescriber in connection with a covered illness, condition, or accidental injury; (b) dispensed by a registered pharmacist; and (c) approved through the Coverage Management Programs described in the Prescription Drug Coverage Management Programs in this section. All Prescription Medications are subject to clinical utilization review when dispensed and to the exclusions listed in the Supplemental Prescription Drug Coverage Exclusions in this section.

Covered Supplemental Prescription Medications prescribed by a Prescriber in connection with a covered illness, condition, or accidental injury and dispensed by a registered pharmacist may be obtained either through the CVS/caremark retail pharmacy program or the CVS/caremark Mail Service Pharmacy program.

The Plan's Supplemental Prescription Drug Coverage Benefit is designed to save you and the Plan money without compromising safety and effectiveness standards. You are encouraged to ask your physician to prescribe Generic Medications or Medications on CVS/caremark's Preferred Drug List whenever possible. Members can still receive any covered Medication, and your physician still maintains the choice of medication prescribed but this may increase your financial responsibility.

### Section 1.1 Copayment Structure

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

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

| | **Up to 30 – day supply** | **Up to 90 – day supply** |
|---|---|---|
| | **Preferred Network Pharmacies (i.e. Participating Pharmacy) (short-term use Medications)** | **CVS/caremark's Mail Service Pharmacy (long-term use – maintenance Medications*)** |
| **Generic Drugs (lowest cost-sharing tier)** | $5.00 | $10.00 |
| **Preferred Brand Drugs** | $20.00 | $40.00 |
| **Non-Preferred Brand Drugs** | $50.00 | $100.00 |
| **Partial Copay Waiver of Non-Preferred Brand Drugs** | $40.00 | $70.00 |
| **Non-Preferred Brand Drugs** *(with generic equivalents)* | Member Pays the Difference | Member Pays the Difference |
| **Erectile or Sexual Dysfunction Drugs** | 50% coinsurance | 50% coinsurance |
| **Out-of-Pocket Maximum** | | Out-of-Pocket Maximum, per person each Calendar Year: $1,000.00 (Applies to mail service/Maintenance Choice® medications only)<br><br>Maintenance Medications* filled at a CVS/pharmacy after second fill are limited to a 30-day supply and are charged the higher copayment. |
| * A Maintenance Medication should not require frequent dosage adjustments and is prescribed for a long-term or chronic condition, such as diabetes, and high blood pressure or is otherwise prescribed for long-term use. Ask your physician if you will be taking a prescribed Medication longer than 60 days. If you continue to refill a Maintenance Medication at a non-CVS/pharmacy after the second fill, you will be charged a higher | | |

copayment, which is the applicable mail service copayment described above. Please note that while Medications can be filled at a retail pharmacy, long-term Medications (medications taken for 60 days or more) will cost more if refilled at a retail pharmacy after the second fill. Members can refill the same medications by mail service or at a CVS/pharmacy at a cost savings. Certain Specialty Medications are available only through the CVS Caremark Specialty Pharmacy and are limited up to a 30-day supply.
NOTE: The list of Medications subject to a higher copayment after the second fill at a retail pharmacy and the list of Specialty Medications available only through CVS Caremark Specialty Pharmacy are subject to change. To find out which Medications are impacted, Members can visit CVS/caremark online at www.caremark.com/calpers or call CVS/caremark Customer Care at 1-855-479-3660, 24 hours a day 7 days a week.
**Examples of common long-term medication or chronic conditions:**
High blood pressure
High cholesterol
Diabetes
**Examples of common short-term or acute conditions:**
Influenza (the "Flu")
Pneumonia
Urinary tract infection

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

All prescriptions will be filled with a FDA-approved bioequivalent generic, if one exists, unless your physician specifies otherwise. A one thousand-dollar ($1,000.00) out-of-pocket maximum applies to long-term mail service and Maintenance Choice (only applies to Generic and Preferred Brands copayments per person, per plan calendar year for mail service/ Maintenance Choice Prescriptions).

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

## Section 1.2 Maintenance Choice

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

## Section 1.3 Coinsurance, "Member Pays the Difference" and "Partial Copay Waiver"

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

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

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

| Drug | Brand plan cost | | Generic plan cost | | Difference | | Generic copay | Member pays* |
|---|---|---|---|---|---|---|---|---|
| Zocor® | $100.00 | - | $15.00 | = | $85.00 | + | $5.00 | $90.00 |
| Valium® | $79.64 | - | $7.50 | = | $72.14 | + | $5.00 | $77.14 |

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

- You may apply for a Partial Copay Waiver Exception of a Non-Preferred Brand Name copayment or a Member Pays the Difference Exception by contacting CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711) to request an Exception form. Your physician must document the Medical Necessity for the Non-Preferred product(s) versus the Preferred product(s) and the available generic alternative(s). The Partial Copay Waiver Exception and Member Pays the Difference Exception is only available for Non-Preferred Brands and excludes Erectile or Sexual Dysfunction Medications.
- Partial Copay Waiver Exception and Member Pays the Difference Exception authorizations will be entered from the date of the approval. Retroactive reimbursement requests will not be granted.

## Section 1.4 Maximum Out-of-Pocket Costs (MOOP)

Maximum out-of-pocket costs (MOOP) are the most a person will pay in a year for copayments for covered benefits for non-Medicare Part D drugs.

After you reach your maximum out-of-pocket costs of $1,000.00 for only long-term medications through mail service/Maintenance Choice, then CalPERS will pay the rest of your annual drug costs for long-term medications through mail service/Maintenance Choice.

The following copayments do not count towards the out-of-pocket maximum:

- 50% coinsurance for sexual or erectile dysfunction drugs
- Non-Preferred Brand Name copayments
- Member Pays the Difference copayment differential
- Partial Waiver of Non-Preferred Brand Name copayments

## Section 1.5 Retail Pharmacy Program

Medication for a short duration, up to a 30-day supply, may be obtained from a Participating Pharmacy by using your PERS Select Medicare Part D PDP ID card.

There are many Participating Pharmacies outside California that will also accept your PERS Select Medicare Part D PDP ID card. At Participating Pharmacies, simply show your ID card and pay either a five dollar ($5.00) copayment for Generic Medications, a twenty dollar ($20.00) copayment for Preferred Brand Name Medications, or a fifty dollar ($50.00) copayment for Non-Preferred Brand Name Medications, or no cost for preventive immunizations. Non-Preferred Brand Name Medications can be purchased for a forty dollar ($40.00) copayment with an approved partial copay waiver.

If you refill a maintenance Medication at a non-Maintenance Choice retail pharmacy after the second fill, you will be charged a higher copayment, which is the applicable mail service copayment described in Section 1.1 under Copayment Structure.

To find a Participating Pharmacy close to you, visit the CVS/caremark website at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711). If you want to utilize a Non-Participating Pharmacy, please follow the procedure for using a Non-Participating Pharmacy. For covered Medications you take on a long-term basis (60 days or more), use CVS/caremark Mail Service Pharmacy, or a CVS/pharmacy for a lower copayment. For more information on CVS/caremark Mail Service Pharmacy, see “How To Use CVS/caremark Mail Service Pharmacy”, visit the CVS/caremark website at www.caremark.com/calpers, or call CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711).

## How To Use The Retail Pharmacy Program Nationwide

### Participating Pharmacy

Take your Prescription to any Participating Pharmacy*. Present your PERS Select Medicare Part D PDP ID card to the pharmacist. The pharmacist will fill the Prescription for up to a 30-day supply of medication. Verify that the pharmacist has accurate information about you and your covered dependents, including date of birth and gender.

*Limitations may apply.

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

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

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

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

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

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

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

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

**Foreign Prescription Drug Claims**: There are no participating pharmacies outside of the United States and its territories. To receive reimbursement for Supplemental Prescription Medications purchased outside the United States, complete a "CVS/caremark Prescription Reimbursement Claim Form" and mail the form along with your pharmacy receipt to CVS/caremark. The Non-Participating Pharmacy must still have a valid pharmacy ID (NPI) in order for the Plan to approve the paper claim. This can be obtained from the pharmacy that you filled the Prescription. To obtain a claim form, visit the CVS/caremark website at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711).

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

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

**Direct Reimbursement Claim Forms**

To obtain a CVS/caremark Prescription Reimbursement Claim Form and information on Participating Pharmacies, visit the CVS/caremark website at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-855-479-3660 (TTY: 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, are covered by the Plan's Prescription Drug Program if at least one of the active ingredients: (a) requires a Prescription; (b) is FDA-approved; and (c) is covered by CalPERS. Only products that are FDA-approved and commercially available will be considered Preferred for purposes of determining copay. The copayment for a compound Medication is based off the pricing of each individual drug used in the compound. The copayment is determined by the ingredient used in the compound that is on the highest tier of the Prescription Drug Benefit Copayment Structure. Compounds that include a Brand Name Drug with a generic equivalent will be subjected to the Member Pays the Difference rule. Compound powders will have Non-Preferred Brand Name copayment. There are three ways to obtain compounded medications through the Plan's Prescription Drug Program: (1) through CVS/caremark Mail Service Pharmacy; (2) through a Participating Retail Pharmacy; or (3) from a Non-Participating compounding pharmacy. The CVS/caremark Mail Service Pharmacy provides compounding services for many Medications; however, CVS/caremark does not compound some Medications. These compounds must be obtained through a Participating Retail Pharmacy or another compounding pharmacy. If a Participating Pharmacy or a Non-Participating Pharmacy is not able to bill online, you will be

required to pay the full cost of the compound Medications at the time of purchase and then submit a direct claim for reimbursement. You will be required to pay the full cost of the Medications at the time of purchase, then submit a direct claim for reimbursement. To receive reimbursement, complete a "CVS/caremark Prescription Reimbursement Claim Form" and mail it to the address indicated on the form. Certain fees charged by compounding pharmacies may not be covered by your insurance. Please call CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711) for details. Exclusions and utilization management programs may apply to compounded medications.

## Section 1.6 CVS/caremark Mail Service Pharmacy Program

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

- **Additional Savings**: You can receive up to a **ninety (90) day supply** of Medication for only ten dollars ($10.00) for each Generic Medication, forty dollars ($40.00) for each Preferred Brand Name Medication, one hundred dollars ($100.00) for each Non-Preferred Brand Name Medication, or seventy dollars ($70.00) for each Partial Copay Waiver of Non-Preferred Brand Name Copayment. In addition to out-of-pocket cost savings, you save additional trips to the pharmacy.
- **Convenience:** Your Medication is delivered to your home by mail.
- **Security:** You can receive up to a 90-day supply of Medication at one time.
- **A toll-free customer service number:** Your questions can be answered by contacting a CVS/caremark Customer Care representative at 1-855-479-3660 (TTY: 711).
- **Out-of-pocket maximum:** Your maximum Calendar Year copayment (per person) through the mail service program and Maintenance Choice is one thousand dollars ($1,000). This only applies to copayments for Generic and Preferred Brands.

**How To Use CVS/caremark Mail Service Pharmacy**

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

1. Ask your physician to prescribe maintenance Medications for up to a ninety (90) day supply (i.e., if once daily, quantity of 90; if twice daily, quantity of 180; if three times daily, quantity of 270, etc.), plus refills if appropriate.
2. Send the following to CVS/caremark in the pre-addressed mail service envelope:

    a. The original Prescription Order(s) – **Photocopies are not accepted**.

b. A completed :CVS/caremark Mail Service Pharmacy Order Form." The "CVS/caremark Mail Service Pharmacy Order Form" can be obtained by visiting the CVS/caremark website at www.caremark.com/calpers, or by contacting CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711) and using the automated phone system or requesting to speak with a customer service representative.

c. A check or money order for an amount that covers your copayment for each Prescription: $10 generic, $40 Preferred Brand Name, $100 Non-Preferred Brand Name or $70 Partial Copay Waiver of Non-Preferred Brand Name. Checks or money orders should be made payable to CVS/caremark. CVS/caremark also has a safe, convenient way for you to pay for your orders called Electronic Check Processing. Electronic Check Processing is an electronic funds transfer system that automatically deducts your copayment from your checking account. For more information or to enroll on-line, visit www.caremark.com/calpers or call CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711). If you prefer to pay for all of your orders by credit card, you may want to join CVS/caremark's automatic payment program. You can enroll by visiting the CVS/caremark website at www.caremark.com/calpers or by calling toll-free 1-855-479-3660 (TTY: 711).

3. You may also have your physician fax your Prescriptions or send them electronically (often called e-prescribing) to CVS/caremark.

   a. Physicians may fax new prescription(s) using "Fast Start" to CVS/caremark at 1-800-378-0323. (CVS/caremark can only accept faxes from your physician.)

   b. To send prescriptions electronically, your physician may enter the Prescription on an electronic handheld device or computer.

4. To order your mail service refill:

   **a. Use CVS/caremark's website**

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

   **b. Call CVS/caremark's Automated Refill Phone System**

   CVS/caremark's automated telephone service gives you a convenient way to refill your Prescriptions at any time of the day or night. Call 1-855-479-3660 (TTY: 711) for CVS/caremark's fully automated refill phone service. When you call, be ready to provide the cardholder's ID number, Member's year of birth, and your credit card number along with the expiration date.

**c. Refill by Mail**

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

5. Medications will not be released by CVS/caremark Mail Service Pharmacy without a form of payment on file.

**How to submit a payment to CVS/caremark**

You should always submit a payment to CVS/caremark when you order prescriptions through CVS/caremark Mail Service Pharmacy, just as if you were ordering a prescription from a retail pharmacy. CVS/caremark accepts the following as types of payment methods:

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

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

If you have questions regarding CVS/caremark Mail Service Pharmacy or to find out if your Medication is on CVS/caremark's Preferred Drug List, visit the CVS/caremark website at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711). All prescriptions received through mail service will be filled with an FDA-approved bioequivalent generic substitute if one exist.

## SECTION 2 Coverage Management Programs

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

The Plan may implement additional new programs designed to ensure that Medications dispensed to its Members are covered under this Plan. **As new 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.

**Prior Authorization/Point of Sale Utilization Review Program**

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

Please visit the CVS/caremark website at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-855-479-3660 (TTY: 711) to determine if your Medication requires prior authorization.

## SECTION 3 Specialty Pharmacy Services

### Section 3.1 CVS Caremark Specialty Pharmacy

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

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

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

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

### Section 3.2 Specialty Preferred Medication

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 do not 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.

## SECTION 4 Exclusions

The following are excluded under the Supplemental Prescription Drug Coverage:

1. Non-medical therapeutic devices, durable medical equipment, appliances and supplies, including support garments, even if prescribed by a physician, regardless of their intended use.*
2. Drugs not approved by the U.S. Food and Drug Administration (FDA)
3. Off label use of FDA approved drugs**, if determined inappropriate through CVS/caremark's Coverage Management Programs.
4. Any quantity of dispensed medications that is determined inappropriate as determined by the FDA or through CVS/caremark's Coverage Management Programs.
5. Drugs or medicines obtainable without a Prescriber's Prescription, often called Over-the-Counter (OTC) drugs or Behind-the-Counter (BTC) drugs, except insulin, diabetic test strips and lancets, and Plan B.
6. Dietary and herbal supplements, minerals, health aids, homeopathics, any product containing a medical food, and any vitamins whether available over the counter or by prescription (e.g., prenatal vitamins, multi-vitamins, and pediatric vitamins), except prescriptions for single agent vitamin D, vitamin K, and folic acid.
7. A Prescription Drug that has an over-the-counter alternative.

8. Prescription single agent non-sedating antihistamines.
9. Anorexiants and appetite suppressants or any other anti-obesity Drugs.
10. Supplemental fluorides (e.g., infant drops, chewable tablets, gels, and rinses).
11. Charges for the purchase of blood or blood plasma.
12. Hypodermic needles and syringes, except as required for the administration of a covered Drug.
13. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
14. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or Medication prescribed for experimental indications.
15. Any Drugs prescribed solely for the treatment of an illness, injury, or condition that is excluded under the Plan.
16. Any Drugs or Medications which are not legally available for sale within the United States.
17. Any charges for injectable immunization agents (except when administered at a Participating Pharmacy), desensitization products or allergy serum, or biological sera, including the administration thereof. *
18. Professional charges for the administration of Prescription Drugs or injectable insulin. *
19. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a hospital or skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility. *
20. Drugs and Medications dispensed or administered in an outpatient setting (e.g., injectable Medications), including, but not limited to, outpatient hospital facilities, and services in the Member's home provided by Home Health Agencies and Home Infusion Therapy Providers.*
21. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, 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.
22. Any quantity of dispensed Drugs or medications which exceeds a thirty (30) day supply at any one time, unless obtained through CVS/caremark Mail Service Pharmacy or the Maintenance Choice program. Prescriptions filled using CVS/caremark Mail Service Pharmacy or the Maintenance Choice program are limited to a maximum ninety (90) day supply of covered drugs or medicines as prescribed by a Prescriber. Specialty Medications are limited to a 30 day supply.
23. Refills of any Prescription in excess of the number of refills specified by a Prescriber.

24. Any Drugs or Medicines dispensed more than one (1) year following the date of the Prescriber's Prescription Order.
25. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a Non-Participating Pharmacy, or the CVS/caremark Mail Service Pharmacy program.
26. Compounded Medications if: (1) there is a medically appropriate formulary alternative, or (2) the compounded medication contains any ingredient or route of administration not approved by the FDA. Compounded Medications that do not include at least one Prescription Drug, are not covered.
27. Replacement of lost, stolen or destroyed Prescription Drugs.
28. Drugs or medications used solely for the purpose of diagnosing and/or treating infertility.

**NOTE: While not covered under the Supplemental Prescription Drug Coverage 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 Supplemental Prescription Drug Coverage 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 Supplemental Prescription Drug Coverage benefit.

## SECTION 5 Prescription Drug Claim Review and Appeals Process for CalPERS Supplemental Prescription Drug Coverage

CVS/caremark manages both the administrative and clinical prescription drug appeals process for CalPERS. If you wish to request a coverage determination, you or your Authorized Representative may contact CVS/caremark's Customer Care at 1-855-479-3660, 24 hours a day, 7 days a week. TTY users should call 711. CVS/caremark Customer Care will provide you with instructions and the necessary forms to begin the process. The request for a coverage determination must be made in writing to CVS/caremark. The written response from CVS/caremark is an initial determination and will include your appeal rights. A denial of the request is an adverse benefit determination (ABD), and may be appealed through the Internal Review process described below. Denials of requests for Partial Copayment Waivers and

Member Pay the Difference Exceptions are ABDs, 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 the person or entity 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 described in section 2 below.

b. All Denials of Direct Reimbursement Claims

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

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

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

### 2. Internal Review

You may request a review of an ABD by writing to CVS/caremark within 180 days of receipt of the ABD. Requests for Internal Review should be directed to:

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

The request for review must clearly state the issue of the review and include the identification number listed on the CVS/caremark Identification Card, and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support the Medical Necessity of the service. If you would like us to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale. (See definition of "Urgent Review" on page 155.)

You may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the request for Internal Review. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

You will be provided, upon request and free of charge, a copy of the criteria or guidelines used in making the decision and any other information related to the determination. To make a request, contact CVS/caremark Customer Care at 1-855-479-3660, 24 hours a day, 7 days a week. TTY users should call 711.

CVS/caremark will acknowledge receipt of your request within 5 calendar days. For standard reviews of prior authorization of Prescription services (Pre-Service Appeal or Concurrent Appeal), CVS/caremark will provide a determination within 30 days of the initial request for Internal Review and includes the following steps:

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

For standard reviews of prescriptions or services that have been provided (Post-Service Appeal), CVS/caremark will provide a determination within 60 days of the initial request for Internal Review.

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

Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the independent External Review process described in section 4 below;

- For FABDs involving benefit, you may pursue the CalPERS Administrative Review process as described in the CalPERS Administration Review section 5 below.

**3. Urgent Review**

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

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**

- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**

- A physician with knowledge of your medical condition determines that your grievance is urgent.

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

**4. Request for Independent External Review**

FABD's that are eligible for independent External Review are those that involve an element of Medical Judgment. An example of Medical Judgment would be where there has been a denial of a prior authorization on the basis that it is not Medically Necessary. If the FABD decision is based on Medical Judgment, you will be notified that you may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to you. You may request an independent External Review, in writing, no later than 4 months from the date of the FABD. The Prescription in dispute must be a covered benefit. 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 these 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 decision or the independent External Review in cases involving Medical Judgment, you may submit a request for CalPERS Administrative Review. You must exhaust

CVS/caremark's Internal Review process and the independent External Review process, when applicable, prior to submitting a request for CalPERS Administrative Review. See the next section entitled "CalPERS Administrative Review and Administrative Hearing" below.

## 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. You must exhaust CVS/caremark's internal grievance process, and the independent External Review process, when applicable, prior to submitting a request for CalPERS Administrative Review.

This request must be submitted in writing to CalPERS within 30 days from the date of the FABD for benefit decisions or the independent External Review decision in cases involving Medical Judgment.

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 the 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.

## CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

### 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 are 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.

## CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

### 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.**

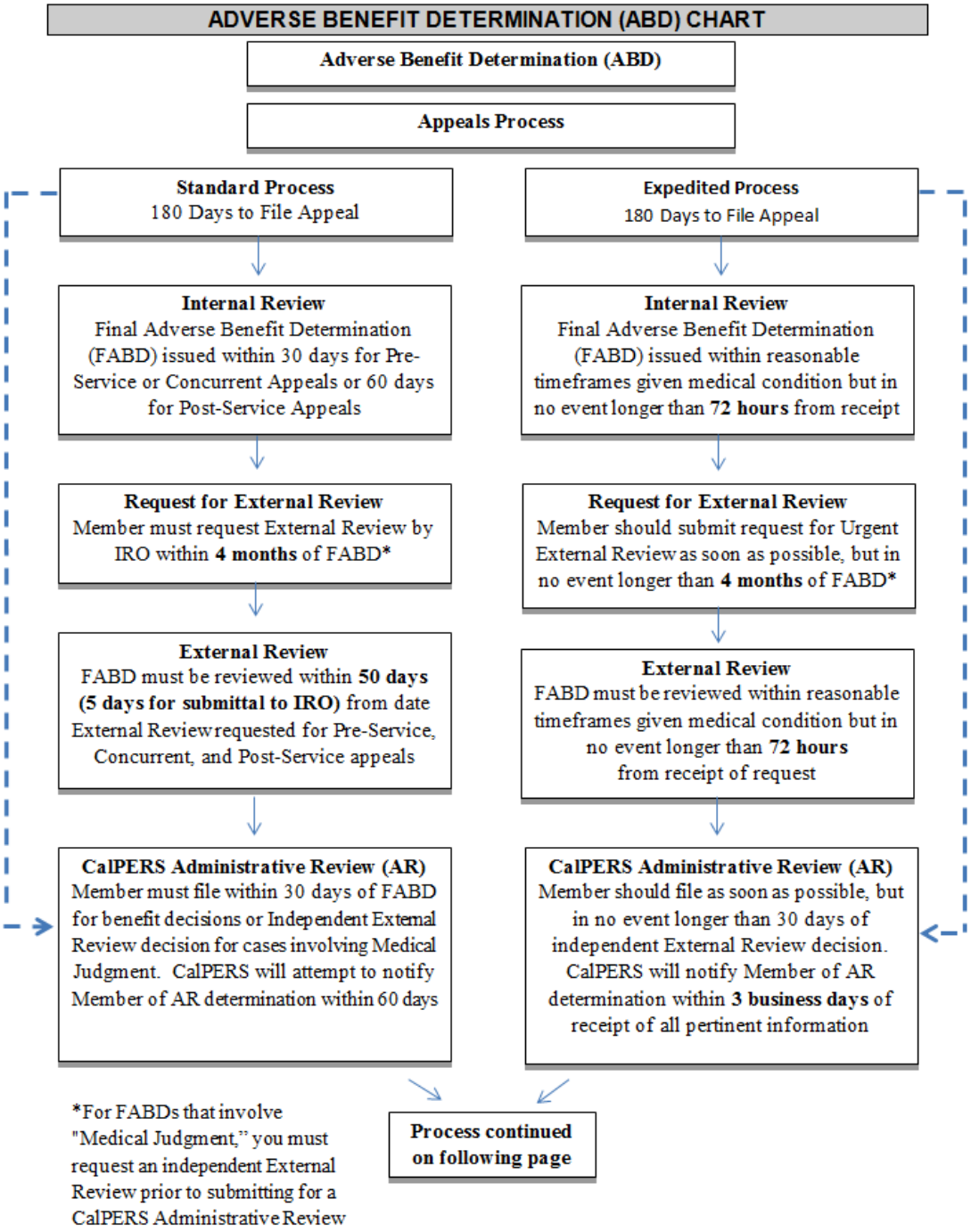
**Summary of Process and Rights of Members under the Administrative Procedure Act**

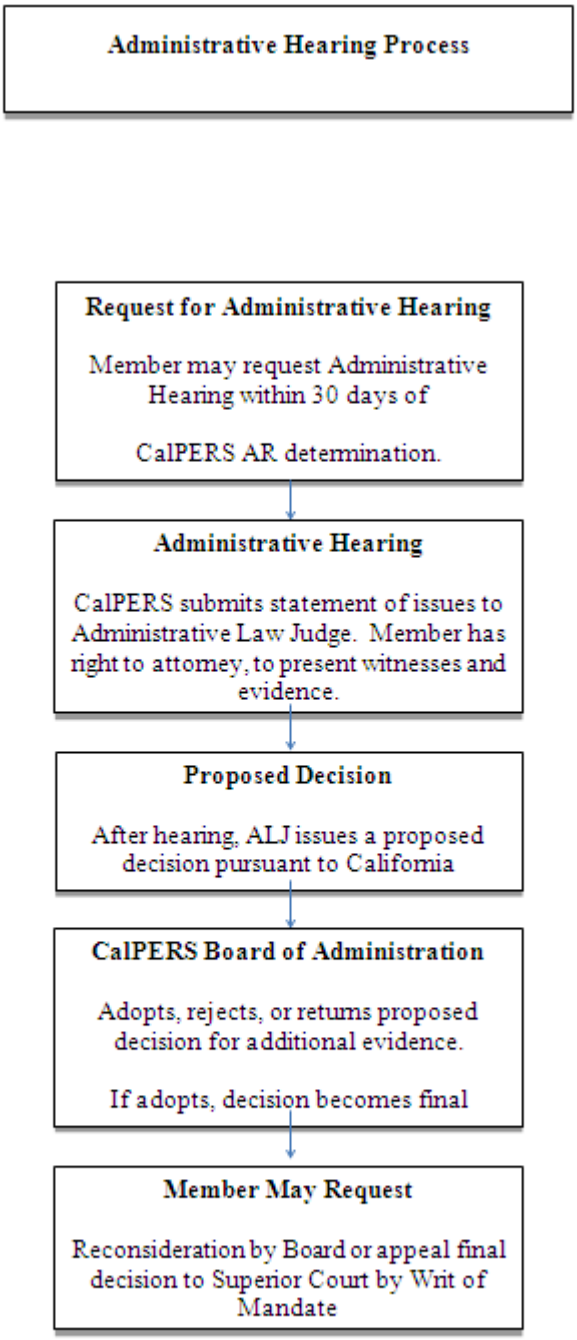
- **Right to records, generally.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or 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 95814


ADVERSE BENEFIT DETERMINATION (ABD) CHART
Adverse Benefit Determination (ABD)
Appeals Process
Standard Process
180 Days to File Appeal
Expedited Process
180 Days to File Appeal
Internal Review
Final Adverse Benefit Determination (FABD) issued within 30 days for Pre-Service or Concurrent Appeals or 60 days for Post-Service Appeals
Internal Review
Final Adverse Benefit Determination (FABD) issued within reasonable timeframes given medical condition but in no event longer than 72 hours from receipt
Request for External Review
Member must request External Review by IRO within 4 months of FABD*
Request for External Review
Member should submit request for Urgent External Review as soon as possible, but in no event longer than 4 months of FABD*
External Review
FABD must be reviewed within 50 days (5 days for submittal to IRO) from date External Review requested for Pre-Service, Concurrent, and Post-Service appeals
External Review
FABD must be reviewed within reasonable timeframes given medical condition but in no event longer than 72 hours from receipt of request
CalPERS Administrative Review (AR)
Member must file within 30 days of FABD for benefit decisions or Independent External Review decision for cases involving Medical Judgment. CalPERS will attempt to notify Member of AR determination within 60 days
CalPERS Administrative Review (AR)
Member should file as soon as possible, but in no event longer than 30 days of independent External Review decision. CalPERS will notify Member of AR determination within 3 business days of receipt of all pertinent information
*For FABDs that involve "Medical Judgment," you must request an independent External Review prior to submitting for a CalPERS Administrative Review
Process continued on following page


Administrative Hearing Process
Request for Administrative Hearing
Member may request Administrative Hearing within 30 days of
CalPERS AR determination.
Administrative Hearing
CalPERS submits statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.
Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California
CalPERS Board of Administration
Adopts, rejects, or returns proposed decision for additional evidence.
If adopts, decision becomes final
Member May Request
Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

## CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

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

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

Administrative Review (AR) – A review conducted by CalPERS after CVS/caremark's Internal Review process or after you elect to participate in the independent External Review process. If you wish to appeal an independent External Review decision, you must submit your appeal to CalPERS for Administrative Review to proceed to Administrative Hearing and exhaust your administrative rights under California law.

Adverse Benefit Determination (ABD) – Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment based on a determination of your eligibility to participate in a plan, and any denial, reduction or termination of, or failure to provide or make payment for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

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

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

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

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

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

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

Internal Review – The review conducted by CVS/caremark for an ABD.

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

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

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

Urgent Review – The process to review a claim for medical care, treatment or Medication with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function; or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Decisions regarding these claims must be made as soon as possible consistent with the medical exigencies involved, but in no event longer than 72 hours upon receipt of the request by CVS/caremark, or 3 business days upon receipt of all pertinent information by CalPERS for the Administrative Review.

# CHAPTER 10

## *Legal Notices*

# Chapter 10. Legal notices

**SECTION 1 Notice about governing law ..... 165**

**SECTION 2 Notice about non-discrimination ..... 165**

**SECTION 3 Notice about Medicare Secondary Payer subrogation rights ..... 165**

**SECTION 4 Other important legal notices ..... 165**

## SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

## SECTION 2 Notice about non-discrimination

We do not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

## SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, PERS Select Medicare Part D PDP, as a Medicare Prescription Drug Plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

## SECTION 4 Other important legal notices

Drug names listed in this and any other Plan documents are the registered and/or unregistered trademarks of third-party pharmaceutical companies unrelated to and unaffiliated with the plan sponsor CVS/caremark or its subsidiaries or affiliates. We include these trademarks here for informational purposes only and do not imply or suggest affiliation between the plan sponsor and such third-party pharmaceutical companies.

# CHAPTER 11

## *Definitions of important words*

# Chapter 11. Definitions of important words

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we do not pay for a drug you think you should be able to receive. Chapters 7 and 9 explain appeals, including the process involved in making an appeal.

**Board** – The Board of Administration of the California Public Employees' Retirement System (CalPERS).

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

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

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,770 in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

**Coinsurance** – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

**Complaint** – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

**Copayment** – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

**Cost Sharing** – Cost sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following two types of payments: (1) any fixed "copayment" amount that a plan requires when a specific drug is received; or (2) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily

cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay.

**Cost-Sharing Tier** – If applicable for your plan, every drug on the list of covered drugs is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription is not covered under your plan, that is not a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**CVS/caremark Customer Care** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact CVS/caremark Customer Care.

**Daily Cost-Sharing Rate –** A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply. Here is an example: If your copay for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription. *Dollar amounts used in this example are for illustrative purposes only and do not reflect your actual copayments.

**Disenroll** or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

**Drug(s) –** See definition under Prescription Drugs.

**Emergency** – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb.

The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

***Evidence of Coverage* (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

**Extra Help** – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**FDA –** U.S. Food and Drug Administration.

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

**Grievance** – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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

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

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

**Income Related Monthly Adjustment Amount (IRMAA)** – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

**Initial Coverage Limit** – The maximum limit of coverage under the Initial Coverage Stage.

**Initial Coverage Stage** – This is the stage before your total Part D drug expenses have reached $3,310.00, including amounts you have paid and what our plan has paid on your behalf for the year.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you are eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Late Enrollment Penalty** – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the Late Enrollment Penalty rules do not apply to you. If you receive Extra Help, you do not pay a Late Enrollment Penalty.

**List of Covered Drugs (Formulary or "Drug List")** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Low Income Subsidy (LIS)** – See Extra Help.

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

**Medicaid (or Medical Assistance)** – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. In California, this program is called Medi-Cal. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

**Medically Accepted Indication –** A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

**Medically Necessary –** Treatment or drugs, supplies, or devices that a prescriber, exercising prudent clinical judgment, would prescribe to a covered individual for the purpose of preventing or treating an illness, injury or disease or its symptoms and that are:

1. In accordance with generally accepted standards of medical practice (i.e., standards that are based on creditable 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 other relevant factor(s)); and
2. Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the covered individual's illness, injury, or disease; and
3. Not primarily for the convenience of the covered individual or prescriber; and
4. Not more costly than alternative medications at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the covered individual's illness, injury or disease.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare a Medicare Cost Plan, or a Medicare Advantage Plan.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage.** Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Cost Plan** – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving Extra Help. Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted. This Coverage Gap Discount Program does not apply to the PERS Select Medicare Part D PDP.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B.

**Medicare Health Plan** – A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**Medication(s) –** See definition under Prescription Drug(s).

**"Medigap" (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (Member of our Plan, or "Plan Member")** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Network Pharmacy** – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Non-Participating Pharmacy** – A pharmacy that has not agreed to CVS/caremark's terms and conditions as a Participating Pharmacy. Members may visit the CVS/caremark website at www.caremark.com/calpers or contact CVS/caremark's Customer Care to locate a Participating Pharmacy.

**Open Enrollment Period –** A set time each year when members can change their health or prescription drug plans or switch to Original Medicare.

**Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare)** – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage

Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Pocket Costs** – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

- **Maximum Out-of-Pocket Costs (MOOP)** – The most a person will pay in a year for deductibles and copays/coinsurance for covered benefits.
- **True Out-of-Pocket Costs (TrOOP)** - The expenses that count toward a person's Medicare drug plan out-of-pocket threshold (for example $4,850.00 in 2016). This includes amounts paid by you or qualified payers on your behalf towards the cost of your covered drugs. Generally payments by family and friends and charities count towards TrOOP, but not payments by other health plans. TrOOP costs determine when a person's catastrophic coverage portion of their Medicare Part D Prescription Drug Plan will begin. In other words, TrOOP defines when you exit the Doughnut Hole or Coverage Gap and enter into the Catastrophic Coverage stage of your Medicare Part D Prescription Drug Plan.

**Over-the-Counter (OTC) Drugs** – A drug product that does not require a prescription under federal or state law.

**PACE plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact CVS/caremark Customer Care (phone numbers are printed on the last page of this booklet).

**Part C** – see "Medicare Advantage (MA) Plan."

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Please note: CalPERS provides supplemental coverage that may differ in structure from

the primary benefit and also cover additional medications. (See your formulary for a specific list of covered drugs and drugs provided by the supplemental coverage.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

**Participating Pharmacy –** A pharmacy that is under an agreement with CVS/caremark to provide Prescription Drug services to Plan Members. Members may visit the CVS/caremark website at www.caremark.com/calpers or contact CVS/caremark Customer Care to locate a Participating Pharmacy.

**Pharmacy –** A licensed facility for the purpose of dispensing Prescription Medications.

**Plan** – Means PERS Select Medicare Part D Prescription Drug Plan (PDP).

**Plan Member –** Any individual enrolled in the PERS Select Medicare Part D PDP.

**Preferred Cost Sharing** – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Prescriber –** A licensed health care provider with the authority to prescribe Medication.

**Prescription –** A written order issued by a licensed prescriber for the purpose of dispensing a Drug.

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

**Prescription Order –** The request for each separate Drug or Medication by a licensed Prescriber and each authorized refill of such request.

**Prior Authorization** – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Service Area** – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you permanently move out of the plan's service area.

**Special Enrollment Period** – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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

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

**Standard Cost Sharing**– Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

**Supplemental Security Income (SSI)** – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

### CVS/caremark Customer Care

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| **CALL** | 1-855-479-3660<br>Calls to this number are free. 24 hours a day, 7 days a week.<br>CVS/caremark Customer Care also has free language interpreter services available for non-English speakers. |
| **TTY** | Dial 711 (National Relay Service) and provide them the CVS/caremark Customer Care number, 1-855-479-3660.<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. 24 hours a day, 7 days a week. |
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