Medicare Part D Prescription Drug Coverage

Preferred Provider Organization

PERS *Choice*

Evidence of Coverage
Medicare Prescription Drug Plan (PDP)

Effective January 1, 2017 – December 31, 2017

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

CalPERS

OPTUMRx®

January 1, 2017 – December 31, 2017

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of the PERS Choice Medicare Part D Prescription Drug Plan (PDP), administered by OptumRx

This booklet gives you the details about your primary Medicare prescription drug coverage from January 1, 2017 – December 31, 2017. It explains how to get 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 5 of this Evidence of Coverage or you can call OptumRx at 1-855-505-8106.

CalPERS has an Employer Group Waiver Plan (EGWP) for Medicare-eligible retirees. This plan is administered by OptumRx. This means that Medicare-eligible retirees and/or dependents have been enrolled in a Group Medicare Part D Plan. CalPERS, through PERS Choice 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 Choice Medicare Part D Prescription Drug Plan.

OptumRx Member Services: For help or information, please call OptumRx Member Services or go to our plan website at optumrx.com/calpers.
1-855-505-8106
TTY users call: 711
Calls to these numbers are free.
Hours of Operation: 24 hours a day, 7 days a week

This plan is offered by *CalPERS*, referred throughout the Evidence of Coverage as "we," "us," or "our." The PERS Choice Medicare Part D Prescription Drug Plan is referred to as "Plan" or "our Plan."

Optum Insurance of Ohio, Inc. is a Medicare approved Part D sponsor and administers this plan through its pharmacy benefit manager, OptumRx, on behalf of your employer, union or trustees of a fund. If you need this information in another language or alternate format (Braille, large print, audio), please contact OptumRx Member Services at the number located on the back of your ID card. Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2018.

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English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-505-8106. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-505-8106. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-505-8106。 我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-505-8106。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-505-8106. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-505-8106. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-505-8106 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-505-8106. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-505-8106번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-505-8106. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-505-8106. سيقوم شخص يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-505-8106 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-505-8106. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-505-8106. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-505-8106. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-505-8106. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-505-8106にお電話ください。日本語を話す人者 が支援いたします。これは無料のサービスです。

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SECTION 1 Introduction

Section 1.1 You are enrolled in the PERS Choice Medicare Part D Prescription Drug Plan (PDP), sponsored by CalPERS

This Evidence of Coverage booklet tells you how to use 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.

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

There are different types of Medicare plans. PERS Choice Medicare Part D Prescription Drug Plan, administered by OptumRx, is a Medicare Prescription Drug Plan. Like all Medicare plans, this Medicare Prescription Drug Plan is approved by Medicare and administered by OptumRx.

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of the PERS Choice Medicare Part D Prescription Drug Plan.

Section 1.3 What if you are new to the PERS Choice Medicare Part D Prescription Drug Plan?

If you are a new member, then 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 OptumRx Member Services (contact information is in the front of this booklet).

Section 1.4 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 the PERS Choice Medicare Part D Prescription Drug Plan covers your care. Other parts of this contract include the List of Covered Drugs (Formulary) and any notices you receive from us about changes or extra conditions that can 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 the PERS Choice Medicare Part D Prescription Drug Plan between January 1, 2017 to December 31, 2017.

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 Choice Medicare Part D Prescription Drug Plan after December 31, 2017. We can also choose to stop offering the plan, or offer it in a different service area, after December 31, 2017.

Medicare must approve our plan each year

The Centers for Medicare & Medicaid Services (Medicare) must approve the PERS Choice Medicare Part D Prescription Drug Plan, administered by OptumRx, each year. You can continue to get Medicare coverage as a member of our plan 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 coverage in our plan as long as:

- CalPERS has determined that you are eligible for this plan.
- You live in our geographic service area (section 2.3 below describes our service area)
- You are entitled to Medicare Part A and you are enrolled in Medicare Part B (**you must have both Part A and Part B**)
- You are a United States citizen or are lawfully present in the United States

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

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's 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 the PERS Choice Medicare Part D Prescription Drug Plan

Medicare is a Federal program and PERS Choice Medicare Part D Prescription Drug Plan is available only to CalPERS members who reside in the United States, the District of Columbia, Puerto Rico and Guam. To remain a member of our plan, you must reside in the service area. 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 OptumRx Member Services (phone numbers are printed in the front 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. You must be a U.S. citizen to be a member of a Medicare plan. If

you become incarcerated, or are no longer lawfully present in the service area, this deems you outside the service area, which means, you are no longer eligible for coverage.

It is also important that you call the Social Security Administration if you move or change your mailing address.

SECTION 3 What other materials will you get from us?

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While you are a member of our plan, you must use our ID card for prescription drugs you get at network pharmacies. If you do not present your card at the pharmacy, you may be responsible for the full cost of the prescription drug, and may or may not be reimbursed by the Plan. If you are at the pharmacy and do not have your card, you can show them your Medicare (red, white and blue) card, or call OptumRx Member Services to verify Coverage.

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your ID card is damaged, lost, or stolen, call OptumRx Member Services right away and we will send you a new card. You may also print a temporary card from the member portal site at optumrx.com/calpers.

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

Section 3.2 The Pharmacy Locator tool: your guide to pharmacies in our network

Each year that you are a member of our plan, we will send you a new pharmacy directory. This pharmacy directory lists our network pharmacies.

What are "network pharmacies"?

Our Pharmacy Locator tool gives you a list of our network pharmacies – that means the pharmacies that have agreed to fill covered prescriptions for our plan members. Visit optumrx.com/calpers to locate a pharmacy.

Why do you need to know about network pharmacies?

You can use the Pharmacy Locator tool 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. You should only use a non-participating pharmacy in emergency situations. If you use a non-participating pharmacy, you may pay more for your prescriptions.

There may be changes to our network of pharmacies for next year.

The abridged pharmacy network listing will be included in this packet, or, you can contact OptumRx Member Services for more information.

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." It tells which Part D prescription drugs and CalPERS supplemental prescription drugs are covered by the PERS Choice Medicare Part D Prescription Drug Plan. The drugs on this list are selected with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare.

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 OptumRx Member Services 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 at optumrx.com/calpers or contact OptumRx Member Services.

Section 3.4 The Explanation of Benefits (the "EOB"): Reports with a summary of payments made for your prescription drugs

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

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

An Explanation of Benefits summary is also available upon request. To get a copy, please contact OptumRx Member Services.

SECTION 4 Your monthly premium for the PERS Choice Medicare Part D Prescription Drug Plan

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 less

There are programs to help people with limited resources pay for their drugs. Chapter 2 tells more about these programs. If you qualify for one of these programs, enrolling in the program might reduce your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **some of the payment information in this Evidence of Coverage may not apply to you**. You will receive a separate notification that tells you about your drug coverage. If you are already enrolled and getting help from one of these programs and do not receive this notification, please call OptumRx Member Services and ask for your "LIS Rider" (the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs.) Phone numbers for OptumRx Member Services are on the front page of this booklet.

In some situations, your plan premium could be more

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 keep their creditable coverage. ("Creditable" means the drug coverage is expected pay on average, at least as much as Medicare's standard prescription drug coverage,) For these members, the plan's monthly premium may be higher. It will be the monthly plan premium plus the amount of their late enrollment penalty.

If you are required to pay the 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.

Note: If you have a late enrollment penalty, you will receive a monthly invoice from OptumRx. If you do not pay the monthly late enrollment penalty premium, you could be disenrolled for failure to pay your plan penalty premium. Therefore, to avoid disenrollment, make sure your late enrollment penalty is paid.

Many members are required to pay other Medicare premiums

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 the extra amount will be.

SECTION 5 Please keep your member records up to date

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

The pharmacists in the plan's network need to have correct information about you. **These network providers use your member record to know what drugs are covered 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, your address, or your 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

If any of this information changes, please let us know by calling OptumRx Member Services (phone numbers are printed in the front of this booklet). 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. That is because we must coordinate any other coverage you have with your benefits under our plan.

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 OptumRx Member Services.

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.

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 is 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 that has more than 100 employees.
    - If you are over 65 and you or your spouse is 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 that 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 Member Services (phone numbers are printed on the back cover 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.

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SECTION 1 PERS Choice Medicare Part D Prescription Drug Plan Contacts (how to contact us, including how to reach the OptumRx Member Services)

How to contact our plan's OptumRx Member Services and other important departments.

For assistance with claims, billing or ID card questions, please call OptumRx Member Services. OptumRx Member Services is available 24 hours a day, 7 days a week, or please visit our website at optumrx.com/calpers. We will be happy to help you.

	Phone	TTY*	Fax	Mailing Address
OptumRx Member Services	1-855-505-8106	711	1-808-536-1050	OptumRx Attn: OptumRx Member Services P.O. Box 3410 Lisle, IL 60532
Coverage Decisions	1-855-505-8106	711	1-866-511-2202	OptumRx Attn: Prior Auth Part D Exceptions P.O. Box 5252 Lisle, IL 60532
Appeals	1-855-505-8106	711	1-866-511-2202	OptumRx Attn: Part D Appeals P.O. Box 5252 Lisle, IL 60532
Comments/ Complaints	1-855-505-8106	711	1-866-511-2202	OptumRx Attn: Part D Grievances P.O. Box 3410 Lisle, IL 60532
Payment Requests	1-855-505-8106	711	1-866-511-2202	OptumRx Attn: Manual Claims P.O. Box 968021 Schaumburg, IL 60196-8021

**This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.*

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 8.

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

How to contact us when you are making a compliant about your Part D coverage or pharmacy.

You can make a compliant 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 8.

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	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

WEBSITE	www.medicare.gov 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. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites." 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 at the number above 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.

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	
CALL	1-800-434-0222 (calls to this number are free) or 1-916-231-5110
EMAIL	news@cahealthadvocates.org
WEBSITE	www.cahealthadvocates.org

For a listing of all SHIP programs, please refer to the Appendix at the end of this booklet.

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

There is a Quality Improvement Organization for each state.

Quality Improvement Organizations have a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Quality Improvement Organizations are independent organizations. It is not connected with our plan.

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

CA Livanta BFCC-QIO Program	
CALL	1-877-588-1123 (calls to this number are free)
ADDRESS	9090 Junction Drive, #10 Annapolis Junction, MD 20701
WEBSITE	www.livanta.com

For a listing of all QIO programs, please refer to the Appendix at the end of this booklet.

SECTION 5 Social Security Administration

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 checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security 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 Social Security 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 Social

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

Social Security Administration	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am ET to 7:00 pm, 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. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid 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.

CA Department of Health Care Services/Health Care Programs	
CALL	**(916) 445-4171**
ADDRESS	P.O. Box 997413 Sacramento, CA 95899
WEBSITE	www.dhcs.ca.gov

For a listing of all Medicaid programs, please refer to the Appendix at the end of this booklet.

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. 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.

If you think you may qualify for Extra Help, call the Social Security Administration (see Section 5 of this chapter for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see Section 6 of this chapter for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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 status, low income as defined by the State, and uninsured/under-insured status.

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 (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

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday 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 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free. Available 9 a.m. to 3:30 p.m., Monday through Friday.
WEBSITE	http://www.rrb.gov

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

If you (or your spouse) get prescription drug benefits through an employer/union or retiree group **other than the PERS Choice Medicare Part D Prescription Drug Plan**, call that employer/union benefits administrator if you have any questions. You can ask about their employer/retiree health or drug benefits, premiums, or enrollment period.

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

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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.

To find out more about this coverage, see your *Medicare & You* handbook.

Please note: PERS Choice Medicare Part D Prescription Drug Plan offers additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan (supplemental prescription drug coverage). Please see Chapter 5 for more information about supplemental coverage.

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 accept Medicare showing that he or she is qualified to write prescriptions. You should ask your prescribers the next time you call or visit if they meet this condition.

- You must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy.*)

- Your drug must be on the plan's List of Covered Drugs (Formulary). We call it the "Drug List". (See Section 3, *Your drugs need to be on the plan's drug list*.)

- Your drug must be considered "medically necessary", meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

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.

A network pharmacy is a pharmacy that has agreed to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by the plan.

Our network includes pharmacies that offer standard cost sharing and pharmacies that offer preferred cost sharing. You may go to either our preferred network pharmacy or other network pharmacies to receive your covered prescription drugs. Your cost sharing may be less at preferred pharmacies. Chapter 4 shows a table of cost sharing amounts.

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

If you are currently taking any long-term medications, you do not have to change from 30-day supplies to 90-day supplies. However, ordering a 90-day supply through our Preferred90 Saver program (Walgreens) pharmacy may cost less than three 30-day supplies of the prescription drug form a non-preferred pharmacy. Considering the long-term nature of your prescription, changing from 30-day supplies to ordering 90-day supplies at a Preferred90 Saver pharmacy (Walgreens) could save you money.

Long-term medications are taking 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 Walgreens pharmacy.** Fill your 90-day supply at any Preferred90 Saver location and pick up your medication at your convenience.
>
> **Option 2: Refill with OptumRx Mail-Order Service.** 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, or visit our website at optumrx.com/calpers, or call OptumRx Member Services.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to either have a new prescription written by a doctor or, if applicable/allowed, 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. To find another network pharmacy in your area, you can get help from OptumRx Member Services, visit optumrx.com/calpers, or use your Pharmacy Directory.

What if you need a Specialty network pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact OptumRx Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate a Specialty pharmacy, call OptumRx Member Services.

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. These drugs are referred to as **"maintenance" drugs**. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

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, please call OptumRx Member Services or visit the website at: optumrx.com/calpers. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 7-10 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You also have three different options to expedite the delivery of your mail-order prescription to 2nd day air, or overnight shipping:

- **Online Refills** – visit optumrx.com/calpers to submit your order online and choose a shipping method.
- **Call OptumRx Member Services** - call 1-855-505-8106 to indicate shipping method.
- **Mail-in the prescription order form** – if you mail in a hard copy of your prescription, you can request your order delivery be expedited by either writing your delivery method on the prescription itself, on the order form, or on a separate sheet of paper included with your form.

NOTE: If you need to have your prescription order expedited, you must call OptumRx Member Services at 1-855-505-8106. We also recommend that you call OptumRx Member Services to verify your expedited delivery and/or order have been processed properly when ordering online or sending in a form.

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. 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 automatic refill program, please contact your pharmacy 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of the automatic refill program, which automatically prepares mail-order refills, please contact us by calling OptumRx.

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 OptumRx to give us your preferred phone number.

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 a way to get a long-term 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.)

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 visit optumrx.com/calpers, or call OptumRx Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services. Our plan's mail-order service allows you to order 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 might 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 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. If you do go to an out-of-network pharmacy for any of the reasons listed above, the Plan will cover up to a one-month supply of drugs.
- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.

In these situations, **please check first with OptumRx Member Services** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you may have to pay a higher amount, or the full cost, (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, 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 this Evidence of Coverage, **we also call it the "Drug List."**

The drugs on this list are selected with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare.

The drugs on the Drug List are only those covered under this Medicare Part D plan (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 drug is medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

PERS Choice Medicare Part D Prescription Drug Plan 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. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs, and generally, the brand-name drug may still be covered.

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.
- 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 includes Generic drugs. This is the lowest cost-sharing tier.
- Cost-Sharing Tier 2 includes Preferred Brand drugs.
- Cost-Sharing Tier 3 includes Non-Preferred Brand drugs.

To find out which cost-sharing tier your drug is in, please reference your 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).*

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. Visit the plan's website (optumrx.com/calpers).

2. Check the most recent Drug List we sent you in the mail. (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 OptumRx Member Services to find out if we cover it.)

3. Call OptumRx Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

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. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor or other prescriber 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.

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 100mg; 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. The sections to follow tell you more about the types of restrictions we use for certain drugs.

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 drugs.)

Getting plan approval in advance (Prior Authorization)

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes plan approval is required so we can be sure that your drug is covered by Medicare rules. 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 safer or more 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. For example, the plan might limit how many refills you can get, or 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 a drug you take or want to take, check the Drug List. For the most up-to-date information, call OptumRx Member Services or check our website (optumrx.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 Member Services 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 determination process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8 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

It is possible that there could be a prescription drug you are currently taking, or one that you or your provider thinks you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

What if the drug you want to take is not covered by the plan? 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.

What if 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.

What if 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 would 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?

Please Note: 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 OptumRx Member Services.

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) until you and your doctor decide it is okay to change to another drug, or while you file an exception.
- 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 covered.

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 doctor 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**.
- 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 were in the plan last year:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of a 30-day supply,

or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and are not in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of your enrollment** in the plan. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those who are new members, and are residents in a long-term care facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your enrollment** in the plan. The first supply will be for a maximum of a 98-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those who have been a member of the plan for more than 90 days, and are a resident of a long-term care facility and need a supply right away:**

  We will cover one 31-day supply, 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 31 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 OptumRx Member Services (phone numbers are in the front of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber 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.

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, there are things you can do:

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call OptumRx Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor or other prescriber to find a covered drug that might work for you.

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 can pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, you provider can help you request an exception to the rule.

If you and your doctor or other prescriber want to ask for an exception, Chapter 8 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.

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, there may be 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 by the Federal Drug Administration.
- **Move a drug to a lower cost-sharing tier**.
- **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 is 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 doctor 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 doctor to switch to the generic or to a different drug that we cover.
    - Or you and your doctor or other prescriber 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 8 (*What to do if you have a problem or complaint*).

- Again, 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 doctor or other prescriber 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 5, or you can contact OptumRx 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 not covered.

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 and its territories.
- Our plan usually cannot cover "Off-label use". This is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

Sometimes "off-label use" is allowed. Coverage 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, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, 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 Choice Medicare Part D Prescription Drug Plan 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 towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4 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 by OptumRx.

4. Any quantity of dispensed medications that is determined inappropriate as determined by the FDA or through OptumRx.

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, homeopathic, 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 a 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 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 service 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 OptumRx mail order and 90-day supplies of maintenance medications filled at a Preferred90 Saver pharmacy. Prescriptions filled using OptumRx mail order or through the Preferred90 Saver 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 changes for a special handling and/or shipping costs incurred through a Participating Pharmacy, a Non-Participating Pharmacy or the OptumRx mail order program.

25. Compound 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 will not pay for the drugs not normally covered. (Please refer to your formulary or call OptumRx Member Services for more information.) 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.

SECTION 8 Show your member identification (ID) card when you fill a prescription

Section 8.1 Show your ID card

To fill your prescription, show your plan member ID card at the network pharmacy you choose. When you show your ID card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. 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 ID card with you?

If you do not have your ID card with you when you fill your prescription, ask the pharmacy to call OptumRx Member Services (phone numbers are on the front of this booklet) 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 6 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 the plan?

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 at any time. (Chapter 9, *Ending your coverage in the plan*, tells how 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 facility?

Usually, a long-term care 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.

If you need more information about a particular long-term care facility, please visit optumrx.com/calpers, check your *Pharmacy Directory*, or contact OptumRx Member Services.

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

If you are a new member and a resident of a long-term care facility, and 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 enrollment. The total supply will be for a maximum of a 98-day supply, or less if your prescription is written for fewer days.

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 31-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 doctor or other prescriber 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 doctor 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 doctor want to ask for an exception, Chapter 8 tells what to do.

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

Your enrollment in the PERS Choice Medicare Part D Prescription Drug Plan 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 this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan cannot cover it.

If your plan covers Medicare Part B drugs, some drugs may be covered under through CalPERS. 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 CalPERS for the drug.

CalPERS is providing supplemental coverage for drugs that would normally be covered under Medicare Part B. For more information, please contact OptumRx.

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 by November 15 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 has drug coverage that pays, on average, at least as much as Medicare's standard 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, of if you cannot find it, contact your Medicare 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?

Do you currently have other prescription drug coverage through your spouse's employer or retiree group, other than with PERS Choice Medicare Part D Prescription Drug Plan? If so,

please contact **that group's benefits administrator.** They 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':

Each year your other employer or retiree group 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 it has drug coverage that pays, on average, at least as much as Medicare's standard 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 doctor to correct the problem.

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

Our MTM program helps our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

This program is provided to members at no cost. A team of pharmacists and doctors developed the program for us. The program can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

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.

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.

We will automatically enroll you in the program if you meet the criteria, and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

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

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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, some drugs are covered under Original Medicare or are excluded by law.

As a member of PERS Choice Medicare Part D Prescription Drug Plan 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."
  - The 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 OptumRx Member Services. You can also find the Drug List on our website at optumrx.com/calpers.

- **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.

- **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. You can also visit optumrx.com/calpers to use the Pharmacy Locator Tool.

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 three drug payment stages?

As shown in the table below, there are three "drug payment stages" for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 *Initial Coverage Stage*	***Stage 2*** *Coverage Gap Stage*	***Stage 3*** *Catastrophic Coverage Stage*
You begin in this payment stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $3,700.	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. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $4,950.	During this stage, the plan will pay most of the cost of your drugs for the rest of the plan year (through December 31, 2017).

As shown in this summary of the three payment stages, whether you move on to the next payment stage depends on how much **you and the plan spend** for your drugs. Payments you make for non-Part D drugs are not included in your "total drug costs."

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 "Explanation of Benefits"

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 send a written report called the Explanation of Benefits (it is sometimes called the "EOB") when you have had one or more prescriptions filled. 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.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

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 member ID 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 ID 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 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 6, of 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 out-of-network pharmacies or other times you 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, 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.** If you receive an Explanation of Benefits 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

OptumRx Member Services. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for PERS Choice Medicare Part D Prescription Drug Plan

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

There is no deductible for PERS Choice Medicare Part D Prescription Drug Plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 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

You begin the Initial Coverage Stage when you fill your first prescription of the year. During this phase, 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 includes Generic drugs. This is the lowest cost-sharing tier.
- Cost-Sharing Tier 2 includes Preferred Brand drugs.
- Cost-Sharing Tier 3 includes Non-Preferred Brand drugs.

To find out which cost-sharing tier your drug is in, please reference your plan's *Drug List*.

Your pharmacy choices

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

- A network pharmacy that is in our plan's network
- A preferred retail pharmacy that is in our 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 reference the plan's Pharmacy Locator tool by visiting optumrx.com/calpers.

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:

- **"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 table below, 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 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 OptumRx.

Your share of the cost when you get Covered Part D prescription drugs from:

Before your $1,000 Maximum Calendar Year Pharmacy Financial Responsibility is met, your cost-sharing amount will be:

	Network Pharmacies & Preferred Pharmacies	**Non-Network Pharmacies**
Cost-Sharing Tier 1 **(Generic drugs)**	You pay $5.00 per prescription (up to a 30-day supply)	You pay the full cost per prescription
Cost-Sharing Tier 2 (Preferred Brand drugs)	You pay $20.00 per prescription (up to a 30-day supply)	You pay the full cost per prescription
Cost-Sharing 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 prescriptions. (Quantity Limits apply)	You pay the full cost per prescription.

	Network Pharmacies & Preferred Pharmacies	Non-Network Pharmacies
Compound medications that contain more than one ingredient will be subject to the copay tier of the highest cost ingredient.		

Section 5.3 You stay in the Initial Coverage Stage until your out-of-pocket costs have reached the $3,700 limit for the calendar year

You stay in the Initial Coverage Stage until your out-of-pocket costs have reached the $3,700 limit for the calendar year.

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

- What you have paid for all the covered drugs you have gotten since you started with your first drug purchase of the year. 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 2017, the amount that the plan paid during the Initial Coverage Stage also counts towards your total drug costs.

PERS Choice Medicare Part D Prescription Drug Plan 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 OptumRx Member Services.

The Explanation of Benefits that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the $3,700 limit in a year.

We will let you know if you reach this $3,700 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

Section 5.4 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, you pay a copay to cover 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 you doctor agrees, 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.

    - Here is an example: Let us say the copay for your drug for a full month's supply (a 30-day supply) is $5. This means that the amount you pay per day for your drug is $0.17. If you receive a 7 days' supply of the drug, your payment will be $0.17 per day multiplied by 7 days, for a total payment of $1.17.

    - You should not have to pay more per day just because you begin with less than a month's supply. Let us go back to the example above. Let us say you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7 days' supply runs out. If you receive a second prescription for the rest of the month, or 23 days more of the drug, you will still pay $1 per day, or $23. Your total cost for the month will be $7 for your first prescription and $23 for your second prescription, for a total of $30 – the same as your copay would be for a full month's supply.

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 5.5 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 "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.)

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 the 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 Calendar Year Pharmacy Financial Responsibility is met, your cost sharing amount will be:

	Network Pharmacies	**Preferred90 Saver Pharmacies**	**Mail Order Pharmacy**
Cost-Sharing Tier 1 (Generic drugs)	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 $10.00 per 90 day prescription. (Up to a 90-day supply.)	You pay $10.00 per 90 day prescription. (Up to a 90-day supply.)
Cost-Sharing 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 $40.00 per 90 day prescription. (Up to a 90-day supply.)	You pay $40.00 per 90 day prescription. (Up to a 90-day supply.)
Cost-Sharing 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 $100.00 per 90 day prescription. (Up to a 90-day supply.)	You pay $100.00 per 90 day prescription. (Up to a 90-day supply.)
Erectile or Sexual Dysfunctional Drugs	You pay 50% per prescriptions. (Quantity Limits apply)	You pay 50% per prescriptions. (Quantity Limits apply)	You pay 50% per prescriptions. (Quantity Limits apply)

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

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,950

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 refer to Section 7 in this Chapter.

You continue to pay the same cost sharing amounts as the Initial Coverage Stage, described on the previous pages, until your yearly out-of-pocket costs reach a maximum amount of $4,950.

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 as a member of a different 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 a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $4,950 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 may 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 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 Member Services to let us know (phone numbers are printed in the front 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. When you reach a total of $4,950 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. Chapter 7, Section 2.1, 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 out-of-pocket costs have reached the $4,950 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

If you do reach the Catastrophic Coverage 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:
  - Coinsurance of 5% of the cost of the drug; or
  - $3.30 copayment for a generic drug or a drug that is treated like a generic. Or an $8.25 copayment for all other drugs.
- Our plan pays the rest of the cost.

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

Section 8.1 Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

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 vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a 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.
   - Other vaccines are considered medical benefits. They are covered under Original Medicare.

2. Where you get the vaccine medication.

3. Who gives you the vaccination shot.

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 vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. 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 vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot.

Situation 1: You buy the vaccine at the pharmacy and you get your vaccination shot 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 administration of the vaccine.

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 6 of this booklet (*Asking the plan to pay its share of a bill you have received for medical services or 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 are in 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 vaccination shot.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, 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 6 of this booklet.
- You will be reimbursed the amount charged by the doctor less the amount for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

Section 8.2 You may want to call us at OptumRx Member Services 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 OptumRx Member Services whenever you are planning to get a vaccination.

- 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"?

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible or you experienced a continuous period of 63 days or more without creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards.) The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

If you have a late enrollment penalty, you will receive a monthly invoice from PERS Choice Medicare Part D Prescription Drug Plan. The late enrollment penalty is part of your plan premiums. If you do not pay your 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.

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

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 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 2016, this average premium amount was $34.10. This amount may change for 2017.

- To get 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 $34.10, which equals $4.77. This amount rounds to $4.80. 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 premium penalty for late enrollment if you are in any of these situations:

- You already have prescription drug coverage at least as good as Medicare's standard 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. Speak with your insurer or your human resources department to find out if your current drug coverage is as at least as good as Medicare's.
    - 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* Handbook or call Medicare at 1-800-MEDICARE (1-

800-633-4227). TTY users 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 can ask us to review 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 OptumRx Member Services at the number on the front of this booklet to find out more about how to do this.

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 premium.

Section 9.5 What happens if you do not pay the extra Part D amount?

If you are required to pay the late enrollment penalty and you do not pay it, you may be disenrolled from the plan and lose prescription drug coverage.

SECTION 10 Do you have to pay the 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. **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 Internal Revenue Service (IRS) tax return is above a certain amount, you will pay an extra amount in addition to your monthly play premium.

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

If you filed an individual tax return and your income in 2016 was:	If you were married, but filed a separate tax return and your income in 2016 was:	If you filed a joint tax return and your income in 2016 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	$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	$13.30
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	$34.20
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	$55.20
Greater than $214,000.00	Greater than $129,000.00	Greater than $428,000.00	$76.20

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. CalPERS Supplemental Prescription Drug Coverage

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SECTION 1 Supplemental Prescription Drug Coverage Benefits

The Supplemental Prescription Drug Coverage is administered by OptumRx. This program will pay for non-Medicare Part D Prescription Medications which are: (a) prescribed by a Prescriber (defined in this section) 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 OptumRx Retail Pharmacy Program or the OptumRx Home Delivery 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 the OptumRx Preferred Drug List whenever possible. Members can still receive any covered Medication, and your Physician still maintains the choice of Medication prescribed but this may increase your financial responsibility.

Although Generic Medications (defined in this publication) are not mandatory, the Plan encourages you to purchase Generic Medications whenever possible. Generic equivalent Medications may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that they have the same quality, strength, purity and stability as the Brand-Name Medications (defined in this publication). Prescriptions filled with Generic equivalent Medications generally have lower Copayments and also help to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

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 OptumRx Home Delivery or Walgreens for Maintenance Medications. Your Copayment will vary depending on whether you use retail, Home Delivery/Walgreens, and whether you select Generic, Preferred or Non-Preferred Brand-Name Medications, or whether you refill Maintenance Medications at a non-Walgreens Pharmacy or OptumRx Home Delivery after the second fill.

The following table shows the copayment structure for the retail Pharmacy and Home Delivery programs:

	Up to 30 – day supply	**Up to 90 – day supply**
	Participating Retail Pharmacy (short-term use Medications) or BriovaRx Specialty Pharmacy	**OptumRx Home Delivery/Walgreens Pharmacy (long term use – Maintenance Medications*)**
Generic	$5.00	$10.00
Preferred Brand (on the OptumRx Preferred Drug List)	$20.00	$40.00
Non-Preferred Brand (Not on the OptumRx Preferred Drug List)	$50.00	$100.00
Partial Copay Waiver of Non-Preferred Brand (Partial Copay Waiver, see the OptumRx appeal process in this chapter)	$40.00	$70.00
Member-Pays the Difference (MPD)	Member Pays the Difference	Member Pays the Difference
Erectile or Sexual Dysfunction Drugs	50% Coinsurance	50% Coinsurance
The Maximum Calendar Year Pharmacy Financial Responsibility per person each Calendar Year for Maintenance Medications received from OptumRx Home Delivery or Walgreens under the Preferred90 Saver is $1,000 (only includes Generic and Preferred Brand copayments and Specialty Medication copayments filled through OptumRx Home Delivery). Erectile or Sexual Dysfunction Drug, and Member Pays the Difference (MPD) Copayments **DO NOT APPLY** to the Maximum Calendar Year Pharmacy Financial Responsibility. Maintenance Medications* not filled at OptumRx Home Delivery or Walgreens after 2nd fill are limited to a 30-day supply and are charged the higher Copayment.		
* A Maintenance Medication should not require frequent dosage adjustments and is prescribed for a long-term or chronic condition, such as diabetes or 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 through a pharmacy other than OptumRx Home Delivery or Walgreens after the second fill, you will be charged a higher Copayment, which is the applicable Home Delivery 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 non-Walgreens retail Pharmacy after the second fill. Members can refill the same Medications by Home Delivery or at a Walgreens Pharmacy at a cost savings.

NOTE: The list of Medications subject to a higher Copayment after the second fill at a non-Walgreens retail Pharmacy and the list of Specialty Medications available only through BriovaRx Specialty Pharmacy are subject to change. To find out which Medications are impacted, Members can visit OptumRx on-line at www.optumrx.com/calpers or call OptumRx Member Services at 1-855-505-8110 (TTY users call 711), 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 maximum $1,000 per person per Calendar Year Copayment applies to only Generic Medications and Preferred Brands filled through OptumRx Home Delivery or Walgreens through the Preferred90 Saver Program and Specialty Medication copayments filled through OptumRx Home Delivery.

Section 1.2 Preferred90 Saver Program

Maintenance Medications for long-term or chronic conditions may be obtained at OptumRx Home Delivery or Walgreens Pharmacy locations, for up to a 90 day supply, under the Preferred90 Saver Program. Preferred90 Saver allows you to choose between convenient Medication Home Delivery with OptumRx and an in-person retail experience with Walgreens using the Plan's lower Home Delivery Copayment structure. Prescriptions for 84 to 90 day supplies of Maintenance Medications can be filled under Preferred90 Saver and your copayment will be the same whether filled through Home Delivery or Walgreens.

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" program: If a Brand Name Medication is selected when a Generic equivalent is available, Members will pay the difference in cost between the Brand Name Medication and the Generic equivalent, plus the Generic Copayments. Exceptions to the Member Pays the Difference program will only be considered for Physician requested Brand Name Medication with a Generic equivalent for Medical Necessity.

Examples of Member Pays the Difference Claims for 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 Member Pays the Difference Exception by contacting OptumRx Member Services at 1-855-505-8110 (TTY users call 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).
- You may apply for a Partial Copay Waiver Exception only for Non-Preferred Brand Medications by contacting OptumRx Member Services at 1-855-505-8110 (TTY users call 711) to request an Exception form. Your Physician must document the Medical Necessity for the Non-Preferred Brand product(s) versus the available Generic alternative(s).
- Partial Copay Waiver Exception and Member Pays the Difference Exception authorizations will be entered from the date of the approval. Retroactive reimbursement requests will not be granted. Erectile or Sexual Dysfunction Medications are excluded.

Section 1.4 Maximum Calendar Year Pharmacy Financial Responsibility

Maximum Calendar Year Pharmacy Financial Responsibility is 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 for only long-term medications through Preferred90 Saver, Specialty Pharmacy, and home delivery only, then CalPERS will pay

the rest of your annual drug costs for Preferred90 Saver, Specialty Pharmacy, and home delivery. This applies to medications covered through your supplemental coverage as well as most drugs which are not covered by Medicare.

The following copayments do not count towards the Maximum Calendar Year Pharmacy Financial Responsibility:

- 50% coinsurance for sexual or erectile dysfunction drugs
- Non-Preferred Brand Name copayments
- Member Pays the Difference copay differential
- Partial Waiver of Non-Preferred 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 Choice Medicare Part D Prescription Drug Plan ID card.

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

If you refill a Maintenance Medication at a Pharmacy other than OptumRx Home Delivery or Walgreens after the second fill, you will be charged a higher Copayment, which is the applicable Home Delivery Copayment described above under Copayment Structure in this chapter.

To find a Participating Pharmacy close to you, simply visit the OptumRx Web site at www.optumrx.com/calpers, or contact OptumRx Member Services at 1-855-505-8110 (TTY users call 711). If you want to utilize a Non-Participating Pharmacy, please follow the procedure for using a Non-Participating Pharmacy described below. For covered Medications you take on a long-term basis (60 days or more), use OptumRx Home Delivery, or a Walgreens Pharmacy for a lower Copayment. For more information on OptumRx Home Delivery, see *How To Use OptumRx Home Delivery* on pages in this chapter, visit the OptumRx Web site at www.optumrx.com/calpers, or call OptumRx Member Services at 1-855-505-8110 (TTY users call 711).

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy
Take your Prescription to any Participating Pharmacy*. Present your PERS Choice Medicare Part D Prescription Drug Plan 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 an OptumRx Prescription Reimbursement Claim Form and mail it to the address indicated on the form. **Claims must be submitted within 12 months from the date of purchase to be covered. Any claim submitted outside the 12 month time period will be denied.**

Payment will be made directly to you. It will be based on the amount that the Plan would reimburse a Participating Pharmacy minus the applicable Copayment.

Example of Direct Reimbursement Claim for a Preferred Brand-Name Medication*

1.	Pharmacy charge to you (Retail Charge)	$ 48.00
2.	Minus the OptumRx Negotiated Network Amount on a Preferred Brand- Name Medication	($ 30.00)
3.	Amount you pay in excess of Allowable Amount due to using a Non- Participating Pharmacy or not using your ID Card at a Participating Pharmacy	$ 18.00
4.	Plus your Copayment for a Preferred Brand-Name Medication	$ 20.00
5.	Your total financial cost would be	$ 38.00

If you had used your ID Card at a Participating Pharmacy, the Pharmacy would only charge the Plan $30.00 for the Drug, and your financial cost would only have been the $20.00 Copayment. Please note that if you paid a higher Copayment after your second fill at retail for a Maintenance Medication, you will not be reimbursed for the higher amount.

As you can see, using a Non-Participating Pharmacy or not using your ID card at a Participating Pharmacy results in substantially more cost to you than using your ID card at a Participating Pharmacy. Under certain circumstances your Copayment amount may be higher than the cost of the Medication, and no reimbursement would be allowed.

*Dollar amounts listed are for illustration only and will vary depending on your particular Prescription.

Vacation Overrides: Members are generally allowed up to a 30-day supply, 2 times per medication, per rolling year.

Foreign Prescription Drug Claims: There are no participating pharmacies outside of the United States. To receive reimbursement for Supplemental Prescription Medications purchased outside the United States, complete an OptumRx Prescription Reimbursement Claim Form and mail the

form along with your pharmacy receipt to OptumRx. 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 OptumRx web site at www.optumrx.com/calpers, or contact OptumRx Member Services at 1-855-505-8110 (TTY users call 711).

Reimbursement for Drugs will be limited to those obtained while living or traveling outside of the United States and will be subject to the same restrictions and coverage limitations as set forth in this Evidence of Coverage document. Excluded from coverage are foreign Drugs for which there is no approved U.S. equivalent, Experimental or Investigational Drugs, or Drugs not covered by the Plan (e.g., Drugs used for cosmetic purposes, Drugs for weight loss, etc.). Please refer to the list of covered and excluded Drugs outlined in the Supplemental Prescription Drug Program section and Supplemental Prescription Drug Exclusions section.

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

Direct Reimbursement Claim Forms

To obtain an OptumRx Prescription Reimbursement Claim Form and information on Participating Pharmacies, visit the OptumRx Web site at www.optumrx.com/calpers, or contact OptumRx Member Services at 1-855-505-8110 (TTY users call 711). You must sign any Prescription Reimbursement Claim Forms prior to submitting the form (and Prescription Reimbursement Claim Forms for Plan Members under age 18 must be signed by the Plan Member's parent or guardian).

Compound Medications

Compound Medications, in which two or more ingredients are combined by the pharmacist, 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. Compound Medications are subject to Coverage Management Programs and Supplemental Prescription Drug Coverage Exclusions listed in this chapter.

Only products that are FDA-approved and commercially available will be considered Preferred for purposes of determining copayment. The Copayment for a compound Medication is based on the pricing of each individual Drug used in the compound. Compound Medications that contain more than one ingredient will be subject to the applicable Copayment tier of the highest cost ingredient.

If a Participating Pharmacy or a Non-Participating Pharmacy is not able to bill online, you will be required to pay the full cost of the compound Medication at the time of purchase and then submit a direct claim for reimbursement. To receive reimbursement, complete the OptumRx 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 OptumRx Customer Service at 1-855-505-8110 (TTY users call 711) for details.

Section 1.6 Home Delivery Program

Maintenance Medications for long-term or chronic conditions may be obtained by mail, for up to a 90 day supply, through the OptumRx Home Delivery Program. Home Delivery offers additional savings, specialized clinical care and convenience if you need Prescription Medication on an ongoing basis. For example:

- **Additional Savings**: You can receive up to a **90 day supply** of Medication for only$10.00 for each Generic Medication, $40.00 for each Preferred Brand-Name Medication, $100.00 for each Non-Preferred Brand-Name Medication or $70.00 for each Partial Copay Waiver of Non-Preferred Brand-Name Copayment. In addition to financial cost savings, you save additional trips to the Pharmacy.
- **Convenience:** Your Medication is delivered to your home by mail.
- **Security:** You can receive up to a 90-day supply of Medication at one time.
- **A toll-free customer service number:** Your questions can be answered by contacting OptumRx Member Services at 1-855-505-8110 (TTY users call 711).
- **The Maximum Calendar Year Pharmacy Financial Responsibility:** Your maximum Calendar Year Copayment (per person) through the Home Delivery Program is $1,000. This only applies to Copayments for Generic and Preferred Brands.

How To Use OptumRx Home Delivery

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

1. Ask your Physician to prescribe Maintenance Medications for up to a 90-day supply (i.e., if once daily, quantity of 90; if twice daily, quantity of 180; if three times daily, quantity of 270, etc.), plus refills if appropriate.

2. Ask your doctor to send your Prescription to OptumRx electronically (known as e-prescribing) or to fax the Prescription. OptumRx can only accept faxed Prescriptions from Physicians.

3. Set up an online account at www.optumrx.com/calpers. Then, log in and select **Get Started**. Choose which Medication you would like to receive through OptumRx Home Delivery.

4. Call OptumRx at 1-855-505-8110 (TTY users call 711), 24 hours a day, 7 days a week. With your permission, we can contact your doctor's office on your behalf to set up home delivery.

5. Complete and return a New Prescription Order form to OptumRx. Forms can be downloaded from **www.optumrx.com/calpers**.

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

   1. The original Prescription Order(s) – **Photocopies are not accepted**.

   2. If you are not paying with a credit card, you must include a check or money order payable to OptumRx for an amount that covers your Copayment for each Prescription.

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

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

2. Download the OptumRx App for your Apple® or AndroidTM smartphone. Open the app, select Medicine cabinet. Choose which Medication you want to refill.

3. Call OptumRx at 1-855-505-8110 (TTY users call 711) and we can help you refill your Medication.

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

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. 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 automatic refill program, please contact your pharmacy 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of the automatic refill program, which automatically prepares mail-order refills, please contact us by calling OptumRx at 1-855-505-8110 (TTY users call 711).

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 OptumRx to give us your preferred phone number

How to submit a payment to OptumRx

You should always submit a payment to OptumRx when you order Prescriptions through OptumRx Home Delivery, just as if you were ordering a Prescription from a retail Pharmacy. OptumRx accepts the following as types of payment methods:

- Check/Money Order
- Credit Card/Debit Card - Visa®, MasterCard®, Discover®, American Express®
- Ship and Bill – Ship and Bill is a way to pay in full or over time without using a credit card. Contact OptumRx if you would like more information.

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

Go to **www.optumrx.com/calpers** to check your plan's formulary to see if your Medication is covered. You can also search for lower cost alternatives.

SECTION 2 Coverage Management Programs

The Plan's Prescription Drug Coverage Management Programs include, but are not limited to the Step Therapy and Prior Authorization Program/Point of Sale Utilization Review Program. Additional programs may be added at the discretion of the Plan. **The Plan reserves the right to exclude, discontinue or limit coverage of Drugs or a class of Drugs, at any time following a review.**

The Plan may implement additional new programs designed to ensure that Medications dispensed to its Members are covered under this Plan. **As new Medications are developed, including Generic versions of Brand-Name Medications, or when Medications receive FDA approval for new or alternative uses, the Plan reserves the right to review the coverage of those Medications or class of Medications under the Plan. Any benefit payments made for a Prescription Medication will not invalidate the Plan's right to make a determination to exclude, discontinue or limit coverage of that Medication at a later date.**

The purpose of Prescription Drug Coverage Management Programs, which are administered by OptumRx 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

Some Prescriptions require a prior authorization to make sure your Prescription meets your plan's coverage rules. When you talk with your doctor, use the pricing tool on the OptumRx App to help confirm whether you need a prior authorization for your Medication and if there are any alternatives that meet the plan's coverage rules. You can also talk about what you need to do to

get your Medication. Approvals for prior authorizations can be granted for up to one year; however the timeframe may be greater or less, depending on the Medication. You and your Prescriber will receive notification from OptumRx of the prior authorization outcome within a few days. Some Medications that require prior authorization may be subject to quantity limits.

Please visit the OptumRx website at www.optumrx.com/calpers, use the Drug Pricing tool in the OptumRx App or contact OptumRx Member Services at 1-855-505-8110 (TTY users call 711) to determine if your Medication requires prior authorization.

Section 3 Specialty Pharmacy Services

Section 3.1 BriovaRx® Specialty Pharmacy Services

BriovaRx, the OptumRx Specialty Pharmacy offers convenient access and delivery of Specialty Medications (as defined in this Evidence of Coverage booklet), many of which are injectable, as well as personalized service and educational support. A BriovaRx 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 BriovaRx at 1-855-4BRIOVA (1-855-427-4682). BriovaRx Specialty Pharmacy hours of operation are 8:30 AM to 10:00 PM EST, Monday through Friday; however, pharmacists are available for clinical consultation 24 hours a day, 7 days a week.

Please contact BriovaRx Specialty Pharmacy at 1-855-4BRIOVA (1-855-427-4682) for specific coverage information.

Specialty Medications will be limited to a maximum 30 day supply.

Section 3.2 Specialty Preferred Medications

Specialty Preferred Medication strategies control costs and maintain quality of care by encouraging prescribing toward a clinically effective therapy. This program requires a Member to try the preferred Specialty Medication(s) within the drug class prior to receiving coverage for the non-preferred Medication. If you 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 Program:

1. Non-medical therapeutic devices, Durable Medical Equipment, appliances and supplies, including support garments, even if prescribed by a Physician, regardless of their intended use. *

2. Drugs not approved by the U.S. Food and Drug Administration (FDA).

3. Off label use of FDA approved Drugs**, if determined inappropriate through OptumRx Coverage Management Programs.

4. Any quantity of dispensed Medications that is determined inappropriate as determined by the FDA or through OptumRx Coverage Management Programs.

5. Drugs or medicines obtainable without a Prescriber's Prescription, often called Over-the-Counter Drugs (OTC) or Behind-the-Counter Drugs (BTC), except insulin, diabetic test strips and lancets, and Plan B.

6. Dietary and herbal supplements, minerals, health aids, homeopathics, any product containing a medical food, and any vitamins whether available over the counter or by Prescription (e.g., prenatal vitamins, multi-vitamins, and pediatric vitamins), except Prescriptions for single agent vitamin D, vitamin K and folic acid.

7. A Prescription Drug that has an over-the-counter alternative.

8. Prescription single agent non-sedating antihistamines.

9. Anorexiants and appetite suppressants or any other anti-obesity Drugs.

10. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses) except as required by law.

11. Charges for the purchase of blood or blood plasma.

12. Hypodermic needles and syringes, except as required for the administration of a covered Drug.

13. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.

14. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or Medication prescribed for experimental indications.

15. Any Drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.

16. Any Drugs or Medications which are not legally available for sale within the United States.

17. Any charges for injectable immunization agents (except when administered at a Participating Pharmacy), desensitization products or allergy serum, or biological sera, including the administration thereof. *

18. Professional charges for the administration of Prescription Drugs or injectable insulin. *

19. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a Hospital or Skilled Nursing Facility, rest home, sanatorium, convalescent Hospital or similar facility. *

20. Drugs and Medications dispensed or administered in an Outpatient setting (e.g., injectable Medications), including, but not limited to, Outpatient Hospital facilities, and services in the Member's home provided by Home Health Agencies and Home Infusion Therapy Providers. *

21. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or Medication furnished by any other Drug or medical services for which no charge is made to the Plan Member.

22. Any quantity of dispensed Drugs or medicines which exceeds a 30 day supply at any one time, unless obtained through OptumRx Home Delivery or the Preferred90 Saver Program. Prescriptions filled using OptumRx Home Delivery or the Preferred90 Saver Program are limited to a maximum 90 day supply of covered Drugs or medicines as prescribed by a Prescriber. Specialty Medications are limited up to a 30 day supply.

23. Refills of any Prescription in excess of the number of refills specified by a Prescriber as allowed per federal/state laws.

24. Any Drugs or Medicines dispensed more than one year following the date of the Prescriber's Prescription Order as allowed per federal/state laws. Note, controlled substances may be less than one year depending on federal/state laws.

25. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a non-Participating Pharmacy, or the OptumRx Home Delivery program.

26. Under the Compound Management Program, compound prescriptions can be excluded if: (1) there is an FDA approved alternative available that has more reliable efficacy and safety; (2) contains a bulk chemical that is not FDA approved and is on our bulk exclusion list; or (3)includes a pre-packaged compound kit.

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 Program benefit, items marked by an asterisk (*) are covered as stated under the Hospital Benefits, Home Health Care, Hospice Care, Home Infusion Therapy and Professional Services provisions of Medical and Hospital Benefits, and Description of Benefits (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

**Drugs awarded DESI (Drug Efficacy Study Implementation) Status by the FDA were approved between 1938 and 1962 when drugs were reviewed on the basis of safety alone; efficacy (effectiveness) was not evaluated. The FDA allows these products to continue to be marketed until evaluations of their effectiveness have been completed. DESI Drugs may

continue to be covered under the CalPERS Supplemental 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 another benefit section of the Plan, it is not a Covered Expense under the Supplemental Prescription Drug Coverage benefit.

SECTION 5 Supplemental Prescription Drug Coverage Claim Review and Appeals Process

OptumRx 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 OptumRx Member Services at 1-855-505-8110 (TTY users call 711). Member Services will provide you with instructions and the necessary forms to begin the process. The request for a coverage determination must be made in writing to OptumRx. If your request is denied, the written response from OptumRx is an initial determination and will include your appeal rights. A denial of the request is an Adverse Benefit Determination (ABD), and may be appealed through the Internal Review process described below. Denials of requests for Partial Copayment Waivers and Member Pay the Difference Exceptions are ABDs, and you may appeal them through the Internal Review process. If the appeal is denied through the Internal Review process, it becomes a Final Adverse Benefit Determination (FABD) and for cases involving Medical Judgment, you may pursue an independent External Review as described below, or for benefit decisions may request a CalPERS Administrative Review.

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

1. Denial of claims of benefits

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

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

You may request an Internal Review for each Medication denied through Coverage Management Programs within 180 days from the date of the notice of initial benefit denial sent by OptumRx. This review is subject to the Internal Review process as described in section 2 below.

OptumRx
c/o Appeals Coordinator
CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

b. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for Prescription Drugs are not payable when first submitted to OptumRx. If OptumRx determines that a claim is not payable in accordance with the terms of the Plan, OptumRx 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 OptumRx. If after resubmission the claim is determined to be payable in whole or in part, OptumRx 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, OptumRx will inform you in writing of the reason(s) for denial of the claim.
If you are dissatisfied with the denial made by OptumRx, 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 OptumRx within 180 days of receipt of the ABD. Requests for Internal Review should be directed to:

OptumRx
c/o Appeals Coordinator
CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

The request for review must clearly state the issue of the review and include the identification number listed on the OptumRx 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”.)

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 OptumRx Member Services at 1-855-505-8110 (TTY users call 711).

OptumRx 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), OptumRx will provide a determination within 30 days of the initial request for Internal Review.

For standard reviews of prescriptions or services that have been provided (Post-Service Appeal), OptumRx will provide a determination within 60 days of the initial request for Internal Review.

If OptumRx upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to you:

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

3. Urgent Review

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if OptumRx 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 OptumRx 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 OptumRx fails to render a decision within the timelines specified above for Internal Review. For a more complete description of independent External Review rights, please see 45 Code of Federal Regulations section 147.136.

5. Request for CalPERS Administrative Review

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

CalPERS Administrative Review and Administrative Hearing

1. Administrative Review

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

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

The request must be mailed to:

CalPERS Health Plan Administration Division

Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

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

If you have additional medical records from Providers that you believe are relevant to CalPERS review, those records should be included with the written request. You should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care.
CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving Urgent Care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than 3 business days from the date all pertinent information is received by CalPERS.

2. Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

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

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

If CalPERS accepts the request for an Administrative Hearing, it will be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you and/or your Authorized Representative may, but 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.

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

Chapter 6. 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 our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask PERS Choice Medicare Part D Prescription Drug Plan 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). Asking for reimbursement in the first three examples below are types of coverage decisions (for more information about coverage decisions, go to Chapter 8 of this booklet).

Here are examples of situations in which you may need to ask our plan to pay you back:

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 call OptumRx Member Services for more information).

   - 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 our network contracted rate minus your cost-share 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 house 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 OptumRx Member Services to see if there is a network pharmacy nearby.

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

If you do not have your plan ID card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the plan to get your member information, but there may be times when you may need to pay if you do not have your card.

- 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.)

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 OptumRx for additional information about how to ask us to pay you back and deadlines for making your request.

- Ensure you provide this information no later than three (3) years from the date of the service. Claims submitted after this 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 on 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 8 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 Choice Medicare Part D Prescription Drug Plan to pay you back

Section 2.1 How and where to send PERS Choice Medicare Part D Prescription Drug Plan to pay you 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 optumrx.com/calpers or call OptumRx Member Services and ask for the form. The phone numbers for OptumRx Member Services are in the front of this booklet.

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

OptumRx
Attn: Manual Claims
PO Box 968021
Schaumburg, IL 60196-8021

Please be sure to contact OptumRx Member Services if you have any questions. 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 We will consider your request for payment

Section 3.1 OptumRx will check to see whether PERS Choice Medicare Part D Prescription Drug Plan should cover the drug and how much PERS Choice Medicare Part D Prescription Drug Plan 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 decide whether to pay it and how much we owe.

- 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 all but your share to you within 14 days. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs.)

- 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 OptumRx tells you that PERS Choice Medicare Part D Prescription Drug Plan will not pay for the drug, you can make an appeal

If you think we have made a mistake in turning you down, 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. The examples of situations in which you may need to ask our plan to pay you back:

- When you use an out-of-network pharmacy to get a prescription filled
- When you pay the full cost for a prescription because you do not have your plan member ID card with you
- When you pay the full cost for a prescription in other situations

For the details on how to make this appeal, go to Chapter 8 of this booklet, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*. The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 8. 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 you have read Section 4, you can go to the Section 5 in Chapter 8 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 us

Section 4.1 In some cases, you should send copies of your receipts to the Plan to help us 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 copay.

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

- For example, a pharmacy might offer a special price on the drug.

- 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.

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 7. 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 alternative formats, etc.)

Our plan has translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternative formats if you need it, upon request. Our OptumRx Member Services has special telephone equipment that is used for people who have difficulties with hearing or speaking.

Plan information is available for your reference on our website at optumrx.com/calpers. To request plan information be mailed to you, please call OptumRx Member Services (phone numbers are on the front cover).

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, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

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** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us OptumRx Member Services. If you have a complaint, such as a problem with wheelchair access, OptumRx Member Services can help.

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

As a member of our plan, you also 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 8 of this booklet 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. The pharmacy provides 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 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 records. If you ask us to do this, we will consider your request and 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 OptumRx Member Services.

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

As a member of PERS Choice Medicare Part D Prescription Drug Plan, you have the right to get several kinds of information from us. If you want any of the following kinds of information, please call OptumRx Member Services:

Information about our plan. This includes, for example, the Evidence of Coverage, List of Covered Drugs (Formulary), Pharmacy Directory, and more. Plan information is available for

your reference on our website at optumrx.com/calpers. To request that a copy of plan information be mailed to you, please contact OptumRx Member Services.

Information about our network pharmacies. For example, you have the right to get information from us about the pharmacies in our network. For an up to date list of the pharmacies in the plan's network, visit optumrx.com/calpers to find the Pharmacy Locator Tool. For more detailed information about our pharmacies, you can call OptumRx Member Services.

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, together with the *List of Covered Drugs (Formulary)*, 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. If you have questions about the rules or restrictions, please call OptumRx Member Services.

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, 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 8 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 8 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 6 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.
- **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 has not followed the instructions in it, you may file a complaint with the State Department of Health.

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 8 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 8, 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.**

Section 1.8 What can you do if you think 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 think 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 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think 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 OptumRx Member Services**.
- 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 OptumRx Member Services**.
- 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 (www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
  - 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 OptumRx Member Services. We are 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 besides our plan, you are required to tell us.*** *Please call 1-855-235-0294 to let us know.*
  - 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 will help you with it.

- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your plan ID 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 are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount to remain a member of the plan.

- ***Tell us if you move.*** *If you are going to move,* ***contact PERS Choice Medicare Part D Prescription Drug Plan immediately to update your records to ensure you receive all necessary correspondence****.*
  - If you move outside the plan service area, you cannot remain a member of our plan. We can help you figure out whether you are moving outside our service 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.
- ***Call OptumRx Member Services 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 OptumRx Member Services are in the front of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 8. 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. OptumRx will help you navigate the appropriate appeals process. If you have any questions, contact OptumRx Member Services.

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

- For some types of problems, you need to use the **process for coverage decisions and making 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 more common 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. Perhaps both are true for you.

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 us. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan 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.

Their services are free. You will find phone numbers in Chapter 2, Section 3 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 just need to find and 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 making appeals deals with problems related to your benefits and coverage for 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 5. You can contact OptumRx Member Services 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 prescription drugs. We make a coverage decision for you whenever you fill a prescription at a pharmacy.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. Usually, there is no problem. We decide the drug is covered and pay our share of the cost. But in some cases we might decide the 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 make an appeal we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more 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 OptumRx Member Services**.
- 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).
- **You should consider getting your doctor or other prescriber involved if possible, especially if you want a "fast" or "expedited" decision.** In most situations involving a coverage decision or appeal, your doctor or other prescriber must explain the medical reasons that support your request. Your doctor or other prescriber cannot request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives").
- **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 OptumRx Member Services and ask for the form to give 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 our plan 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 outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's List of Covered Drugs (Formulary) and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **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.
- For details about what we mean by Part D drugs, the List of Covered Drugs, 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
  - 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 drug on a higher cost-sharing tier

  - 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 but we require you to get approval from us before we will cover it for you.)

- 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 this 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.) 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. 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.) 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.) 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 the plan 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 three 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 plan's List of Covered Drugs (Formulary).** We call it the "Drug List."

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 the drug. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

2. **Removing a restriction on the plan's coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on the plan's List of Covered Drugs (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 may include:
  - *Requirement to use the generic version* of a drug instead of the brand-name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *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.")
  - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.

If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on the plan's Drug List is in one of three 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 preferred price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

If your drug is in Tier 3 you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2. This would lower your share of the cost for the drug. We cannot change the cost-sharing tier for any drug in the High-Cost drug tier (Tier 4).

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 written 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. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all alternative drugs in the lower cost-sharing tiers will not work as well for you.

Our plan 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 our plan 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 decision." You cannot ask for a fast 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 our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision 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 that asks us to pay for our share of the cost for medical care or 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 our plan to pay you back for a drug,** start by reading Chapter 6 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs.* Chapter 6 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 "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. 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 Coverage Determination Request Form, which is available on our website.

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

Legal Terms	A "fast decision" is called an **"expedited decision."**

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.

- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - You can get a fast 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 decision," we will automatically agree to give you a fast decision.**

- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast 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 decision, we will automatically give a fast decision.

- The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (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: Our plan considers 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 tell 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.

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 tell 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.

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 tell 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 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.

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

- If our plan says 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	When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact our plan 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 (or your representative or your doctor or other prescriber) must contact our plan.**
  - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs.*

Make your appeal in writing by submitting a signed request.

- **If you are asking for a standard appeal, make your appeal by submitting a written request.**

- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at OptumRx Member Services.**
- **We must accept any written request,** including a request submitted on the Coverage Determination Request Form, which is available on our website.
- **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.
- **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 appeal."**

- If you are appealing a decision our plan 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 decision" in Section 5.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and 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 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,** we must provide the coverage we have agreed to provide within 72 hours.

- **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 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 30 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 our plan says 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 our plan says 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 our plan 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 must contact the Independent Review Organization and ask for a review of your case.

- If our plan says 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 outside, independent organization that is hired by Medicare**. This organization is not connected with our plan 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 our plan.

- 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 s**end 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.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the 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 if the dollar value of the coverage you are requesting is high enough 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 certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, 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.

- **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 can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with you appeal. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of 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 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare 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. It depends on your situation. If the Medicare 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 stage of the appeals process.

- This is the last step of the administrative appeals process.

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 5.

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".

See chart on next page:

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? • Are you unhappy with how our Member Services has treated you? • 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 Member Services or other staff at the plan? o 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? • Do you think written information we have given you is hard to understand?
Timeliness (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. 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: • 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. • 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. • 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. • 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 OptumRx Member Services is the first step.** If there is anything else you need to do, OptumRx Member Services will let you know. Call OptumRx Member Services at 1-855-505-8106. TTY users call 711. Calls to these numbers are free. OptumRx Member Services is available 24 hours a day, 7 days a week.
  For more information about the Medicare Grievance Process, call OptumRx Member Services.

- **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 do this, it means that we will use our *formal procedure* for answering grievances. Here is how it works:

  Send your compliant in writing and mail it to us at:

  OptumRx
  Attn: Part D Grievances
  P.O. Box 3410
  Lisle, IL 60532-3410

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 calendars 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 benefit.
    - You may submit this type of complaint by phone by calling OptumRx Member Services.

- For a fast complaint about a denial regarding your request for expedited coverage determinations or redeterminations, you may submit the complaint by calling OptumRx Member Services. We will contact you with 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 OptumRx Member Services right away.** The complaint must be made within 60 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 response" to a coverage decision or 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 a **"fast 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 days, but we may take up to 44 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 days (44 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 our plan 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 the Appendix 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 our plan 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 Choice Medicare Part D Prescription Drug Plan 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). TTY/TDD users can call 1-877-486-2048.

Chapter 9. Ending your coverage 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 the PERS Choice Medicare Part D Prescription Drug Plan may be *voluntary* (your own choice) or *involuntary* (not your own choice): If you decide to leave our 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 coverage.

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 the PERS Choice Medicare Part D Prescription Drug Plan, sponsored by CalPERS, you cannot be enrolled in the Supplement to Original Medicare Plan and will lose your CalPERS medical benefits.

SECTION 2 When can you end your membership in our plan?

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period or the Special Enrollment Period

Members of the PERS Choice Medicare Part D Prescription Drug Plan fall into a Special Enrollment Period because you are part of an Employer Group Waiver Plan, which means you are allowed to end your membership anytime throughout the year.

What can you do? 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. If you choose to enroll in another Medicare Prescription Drug Plan that is not part of CalPERS health plan, then you may not maintain enrollment in the PERS Choice Medicare Part D Prescription Drug Plan.

- 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 the PERS Choice Medicare Part D Prescription Drug Plan.

- A Medicare Advantage plan. A Medicare Advantage 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 Advantage plans also include Part D prescription drug coverage.
  - If you enroll in most Medicare Advantage plans (meaning a non-CalPERS health plan), you will automatically be disenrolled from the PERS Choice Medicare Part D Prescription Drug Plan 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 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 drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard prescription drug coverage.)

When will your membership end? Your coverage will usually end on the first day of the month after we receive your request to change your plan.

Section 2.2 Where can you get more information about when you can end your enrollment?

If you have any questions or would like more information on when you can end your enrollment:

- You can **call OptumRx Member Services.**
- You can find the information in the ***Medicare & You*** 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 You end your membership by enrolling in another plan

To end your membership in our plan, you simply enroll in another Medicare plan during one of the open enrollment periods. However, there are a couple of exceptions:

One exception is when you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact the PERS Choice Medicare Part D Prescription Drug Plan and 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 the Medicare Part D Plan sponsored by CalPERS, you will lose your CalPERS medical benefits.

Note: If you disenroll form 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.)

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. You will automatically be disenrolled from this plan 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 this plan when your new plan's coverage begins. • 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 Member Services (phone numbers are printed on the back cover 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. **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 drug plan later. See Chapter 4, Section 10 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • 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 the PERS Choice Medicare Part D Prescription Drug Plan, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your prescription drugs through PERS Choice Medicare Part D Prescription Drug Plan.

You should continue to use our network pharmacies to get your prescriptions filled until your membership in PERS Choice Medicare Part D Prescription Drug 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 The PERS Choice Medicare Part D Prescription Drug Plan must end your coverage in the plan in certain situations

Section 5.1 When must we end your coverage in the plan?

The PERS Choice Medicare Part D Prescription Drug Plan must end your coverage in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you enroll in another Medicare Part D Plan
- If you move out of the plan service area for more than twelve months. The service area includes the 50 United States, the District of Columbia, Puerto Rico and Guam. If you become incarcerated.
- If you are no longer a United States citizen or lawfully present within the service area.
- 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 member ID card to get prescription drugs. (If we end your coverage because of this reason, Medicare may have your case investigated by the Inspector General.

- If you are required to pay the extra Part D amount 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?

You can call OptumRx Member Services if you have questions or would like more information on when we can end your membership.

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 coverage. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7 for information about how to make a complaint.

Chapter 10. Legal notices

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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, religion, sex, health, ethnicity, creed, age, color, gender, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, geographic location, or national origin. All organizations that provide Medicare Advantage 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, Section 1557 of the Affordable Care Act, and 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, OptumRx, 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.

Chapter 11. Definitions of important words

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan does not pay for a drug, item, or service you think you should be able to receive. Chapter 8 explains 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.

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 $4,950 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs Medicare. Section 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a compliant" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problem related to quality of care, waiting times, and the customer service you received.

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.) It 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 – 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.

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 cover, 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.

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 your are required to pay a copay. A daily cost-sharing rate is the copay divide 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).

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 illness, injury, severe pain, or a medical condition that is quickly getting worse.

Employer Group Waiver Plan (EGWP) – Medicare Part D plan that is sponsored by a former employer union or trustees of a fund.

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 the preferred 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 government agency, prior to use, and where such approval has not been granted at the time the not approved or recognized as being in accord with accepted professional medical standards, but nevertheless are authorized by law or government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigation. Any issue as to whether a protocol, procedure, practice, medical theory, or treatment is experimental or investigational will be resolved by OptumRx, which will have full discretion to make such determination on behalf of the Plan and its participants.

Extra Help/Low Income Subsidy – 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, generic drugs cost less than brand name drugs.

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 Organization.

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 – The stage where you pay a copayment or coinsurance for your drugs until your out-of-pocket costs have reached the $3,700 limit for the calendar 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 expects 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.

List of Covered Drugs (Formulary or "Drug List") – A list of covered drugs provided 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.

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.

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 a 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;
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).

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 (Hospital) and Part B (Medical) 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. 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 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 manufactures. For this reason, most, but not all, brand name drugs are discounted. This Coverage Gap Discount Program does not apply to PERS Choice Medicare Part D Prescription Drug Plan.

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 Program, 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 the terms and conditions of OptumRx as 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.

OptumRx Member Services – A department within our Plan responsible for answering your questions about your enrollment, benefits, grievances, and appeals. See Chapter 2 for information about how to contact OptumRx Member Services.

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 towards a person's Medicare Drug plan out-of-pocket threshold (for example $4,950 in 2017). 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 portion of their Medicare Part D Prescription Drug Plan will begin. In other words, TrOOP defines when you exit the 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.

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.) 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 OptumRx to provide Prescription Drug services to Plan Members. Members may visit the OptumRx website at optumrx.com/calpers or contact OptumRx Member Services to locate a Participating Pharmacy.

Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our plan at lower cost-sharing levels than apply at a non-preferred network pharmacy.

Pharmacy – A licensed facility for the purpose of dispensing Prescription Medications.

Plan – Means PERS Choice Medicare Part D Prescription Drug Plan (PDP)

Plan Member- Any individual enrolled in the PERS Choice Medicare Part D Prescription Drug Plan.

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 96) such other drus 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 a 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) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2, Section 4 for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO.

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 – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare.

Specialty Medication- Means drugs that have one or more of the following characterizes: (1) therapy of a 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 Medication.

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.

State Pharmaceutical Assistance Program					
State	**Agency Name**	**Street Address**	**City/State**	**Zip**	**Phone number**
CO	Colorado Bridging the Gap	4300 Cherry Creek Drive South	Denver, CO	80246	(303) 692-2783 or (303) 692-2716
CT	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled - (ConnPACE)	P.O. Box 5011	Hartford, CT	06102	(800) 423-5026 or (860) 832-9265
DE	Delaware Prescription Assistance Program (DPAP)	P.O. Box 950	New Castle, DE	19720	(800) 996-9969 ext. 2
DE	Delaware Chronic Renal Disease Program	113 Church Ave	Milford, DE	19963	(800) 464- 4357 (302) 424-7180
ID	Idaho AIDS Drug Assistance Program (IDAGAP)	P.O. Box 83720	Boise, ID	83720	(800) 926-2588 or (208) 334-5943
IN	Hoosier Rx	402 W Washington Street, Room W374, MS07	Indianapolis, IN	46206	(317) 234-1381 or (866) 267-4679
ME	Low Cost Drugs for the Elderly or Disabled Program	242 State Street	Augusta, ME	04333	(866) 796-2463
MD	Maryland Senior Prescription Drug Assistance Program (SPDAP)	628 Hebron Ave, Suite 212	Glastonbury, CT	06033	(800) 555-9950
MA	Prescription Advantage Program	P.O. Box 15153	Worcester, MA	01615	(800) 243-4636 Ext. 2
MO	Missouri Rx Plan	P.O. Box 6500	Jefferson City, MO	65102	(800) 375-1406
MT	Montana Big Sky Rx Program	P.O. Box 202915	Helena, MT	59620	(866) 369-1233 or (406) 444-1233
NV	Nevada Senior Rx Program & Disability Rx	3416 Goni Rd, Suite D-132	Carson City, NV	89706	(866) 303-6323 or (775) 687-4210
NJ	Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), Senior Gold Prescription Discount Program	P.O. Box 715	Trenton, NJ	08625	(800) 792-9745
NJ	Division of Medical Assistance and Health Services	P.O. Box 712	Trenton, NJ	08625	(800) 356-1561
NY	EPIC- Elderly Pharmaceutical Insurance Coverage	P.O. Box 15018	Albany, NY	12212	(800) 332-3742

State Pharmaceutical Assistance Program					
NC	North Carolina HIV SPAP	1902 Mail Service Center	Raleigh, NC	27699	(877) 466-2232 or (919) 733-7301
PA	PACE (Pharmaceutical Assistance Contract for the Elderly), PACENET (Pennsylvania PACE Needs Enhancement Tier)	P.O. Box 8806	Harrisburg, PA	17105	(800) 225-7223
PA	Special Pharmaceutical Benefits Program for Mental Health and for HIV/AIDS	P.O. Box 8021	Harrisburg, PA	17105	(800) 922-9384 (Mental Health), (800) 443-4459 (HIV/AIDS)
RI	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	74 West Road, Hazard Bldg	Cranston, RI	02920	(401) 462-3000 or (401) 462-0740
TX	Texas HIV State Pharmacy Assistance Program (SPAP)	P.O. Box 149347	Austin, TX	78714	(800) 255-1090 Ext. 3004
TX	Texas Kidney Health Care Program (KHC)	P.O. Box 149347	Austin, TX	78714	(800) 222-3986 or (512) 776-7150
VT	VPharm, Health Access Plan (VHAP-Pharmacy), VSCRIPT, and VSCRIPT Expanded	312 Hurricane Lane, Suite 201	Williston, VT	05495	(800) 250-VHAP (8427) or (802) 879-5900
VA	Virginia HIV SPAP	P.O. Box 5930	Midlothin, VA	23112	(800) 366-7741
VI	Senior Citizens Affairs Pharmaceutical Assistance Program	1303 Hospital Ground Knud Hansen Complex, Building A	St. Thomas, VI	00802	(340) 774-0930
WA	Washington State Health Insurance Pharmacy Assistance Program	P.O. Box 1090	Great Bend, KS	67530	(800) 877-5187
WI	Wisconsin SeniorCare Program	P.O. Box 6710	Madison, WI	53716	(800) 657-2038
WI	Chronic Renal Disease, Cystic Fibrosis Program	P.O. Box 6410	Madison, WI	53716	(800) 947-9627 or (800) 362-3002

State Medicaid Offices					
State	**Agency Name**	**Street Address**	**City/State**	**Zip**	**Phone Number**
AL	Medicaid Agency of Alabama	501 Dexter Avenue, P.O. Box 5624	Montgomery, AL	36103	(800) 362-1504
AK	Department of Health and Social Services	350 Main Street, Room 404	Juneau, AK	99811	(947) 465-3030
AR	Department of Human Services	P.O. Box 1437 Donaghey Plaza South	Little Rock, AR	72203	(501) 682-1001
AZ	Health Care Cost Containment of Arizona	801 E. Jefferson Street, MD 4100	Phoenix, AZ	85034	(800) 654-8713 or (602) 417-5437
CA	Department of Health Care Services/Health Care Programs	P.O. Box 997413	Sacramento, CA	95899	(916) 445-4171
CO	Department of Health Care Policy and Financing	1570 Grant Street	Denver, CO	80203	(800) 221-3943
CT	Department of Social Services	25 Sigourney Street	Hartford, CT	06106	(800) 842-1508
DC	Department of Health Care Financing	441 4th Street, NW, 900S	Washington, D.C.	20001	(202) 442-4790
DE	Delaware Health and Social Services	1901 N. DuPont Highway, Lewis Bldg.	New Castle, DE	19720	(302) 255-9010
FL	Agency for Health Care Administration	2727 Mahan Drive	Tallahassee, FL	32308	(888) 419-3456
GA	Georgia Department of Community Health	2 Peachtree Street, NW	Atlanta, GA	30303	(404) 656-4507
HI	Department of Human Services (Med-Quest Division)	P.O. Box 339	Honolulu, HI	96809	(800) 316-8005
IA	Department of Human Services	P.O. Box 36510	Des Moines, IA	50315	(877) 446-3787
ID	Department of Health and Welfare	P.O. Box 83720	Boise, ID	83720	(208) 334-5578
IL	Department of Healthcare and Family Services	203 S Grand Avenue, East	Springfield, IL	62763	(217) 785-7030
IN	Family and Social Services Administration	P.O. Box 7083, 402 W. Washington Street	Indianapolis, IN	46204	(800) 446-1993
KS	Department of Social and Rehabilitation Services of Kansas	915 SW Harrison Street	Topeka, KS	66612	(888) 369-4777
KY	Department of Medicaid Services	P.O. Box 2110	Frankfort, KY	40602	(800) 635-2570

State Medicaid Offices					
LA	Department of Health and Hospitals	P.O. Box 91278	Baton Rouge, LA	70821	(225) 342-9500
MA	Office of Health and Human Services	600 Washington Street	Boston, MA	02111	(800) 841-2900
MD	Department of Health and Mental Hygiene	P.O. Box 17259	Baltimore, MD	21203	(800) 492-5231
ME	Department of Health and Human Services	442 Civic Center Drive 11 State House Station	Augusta, ME	04333	(800) 977-6740
MI	Department of Community Health	Capitol View Building, 201 Townsend St	Lansing, MI	48913	(517) 373-3740
MN	Department of Human Services	444 Lafayette Road North	St. Paul, MN	55155	(800) 333-2433
MO	Department of Social Services	221 West High Street, P.O. Box 1527	Jefferson City, MO	65102	(800) 392-2161
MS	Division of Medicare	239 N Lamar Street, Suite 801, Robert E Lee Bldg	Jackson, MS	39201	(800) 421-2408
MT	Department of Public Health and Human Services	1400 Broadway, Cogswell Building, P.O. Box 8005	Helena, MT	59604	(800) 362-8312
NC	Department of Health and Human Services	2501 Mail Service Center	Raleigh, NC	27699	(800) 662-7030
ND	Department of Human Services	600 E. Boulevard Avenue, Dept 325	Bismarck, ND	58505	(800) 755-2604
NE	Department of Health and Human Services	P.O. Box 95044	Lincoln, NE	68509	(800) 430-3244
NH	Department of Health and Human Services	129 Pleasant St	Concord, NH	03301	(800) 852-3345
NJ	Department of Human Services	Quakerbridge Plaza, Building 7, P.O. Box 712	Trenton, NJ	08625	(800) 356-1561
NM	Medical Assistance Division/ Human Services Department	P.O. Box 2348	Santa Fe, NM	87504	(888) 997-2583
NV	Department of Human Resources, Aging Division	1100 East William Street, Suite 101	Carson City, NV	89701	(775) 684-7200

State Medicaid Offices					
NY	New York State Department of Health	Governor Nelson A. Rockefeller Empire State Plaza, Corning Tower Bldg	Albany, NY	12237	(800) 541-2831
OH	Department of Job and Family Services	50 West Town Street, Suite 400	Columbus, OH	43215	(800) 324-8680
OK	Health Care Authority	4545 N Lincoln Blvd, Suite 124	Oklahoma City, OK	73105	(800) 522-0310
OR	Department of Human Services	500 Summer Street, NE, 3rd Floor	Salem, OR	97310	(800) 527-5772
PA	Department of Public Welfare	P.O. Box 2675	Harrisburg, PA	17105	(800) 692-7462
RI	Department of Human Services	600 New London Avenue	Cranston, RI	02921	(800) 984-8989
SC	Department of Health and Human Services	P.O. Box 8206	Columbia, SC	29202	(888) 549-0820
SD	Department of Social Services	700 Governors Drive, Richard F Kneip Bldg	Pierre, SD	57501	(800) 452-7691
TN	Bureau of TennCare	310 Great Circle Rd.	Nashville, TN	37243	(866) 311-4287
TX	Health and Human Services Commission	4900 N. Lamar Boulevard, 4th Fl.	Austin, TX	78751	(888) 834-7406
UT	Department of Health	288 North 1460 West, P.O. Box 143101	Salt Lake City, UT	84114	(800) 662-9651
VA	Department of Medical Assistance Services	600 East Broad Street, Suite 1300	Richmond, VA	23219	(800) 552-8627
VT	Agency of Human Services	103 South Main Street	Waterbury, VT	05671	(800) 250-8427
WA	Department of Social & Health Services	P.O. Box 45505	Olympia, WA	98504	(800) 562-3022
WI	Department of Healthcare and Family Services	1 West Wilson Street	Madison, WI	53703	(800) 362-3002
WV	Department of Health and Human Resources	350 Capitol Street, Room 702	Charleston, WV	25301	(304) 558-1700
WY	Wyoming Department of Health	401 Hathaway Building	Cheyenne, WY	82002	(307) 777-7531

State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
AL	Medicaid Agency of Alabama	(800) 362-1504	(334) 242-5000	
AK	Alaska Department of Health and Social Services	(800) 780-9972		
AZ	Health Care Cost Containment of Arizona	(800) 523-0231	(602) 417-7000	(602) 417-7700
AR	Department of Human Services of Arkansas	(800) 482-5431	(501) 682-8233	(800) 482-8988
CA	California Department of Health Services		(916) 636-1980	
CO	Department of Health Care Policy and Financing of Colorado	(800) 221-3943	(303) 866-3513	
CT	Department of Social Services of Connecticut	(800) 842-1508	(860) 424-4908	
DE	Delaware Health and Social Services	(800) 372-2022	(302) 255-9500	
FL	Agency for Health Care Administration of Florida	(866) 762-2237	(850) 487-1111	
GA	Georgia Department of Community Health	(800) 869-1150	(404) 656-4507	
HI	Department of Human Services of Hawaii	(800) 316-8005	(808) 524-3370	
ID	Idaho Department of Health and Welfare	(800) 926-2588	(208) 334-6700	
IL	Illinois Department of Healthcare and Family Services	(800) 226-0768	(217) 782-4977	
IN	Family and Social Services Administration of Indiana	(800) 403-0864	(317) 233-4454	
IA	Department of Human Services of Iowa	(800) 338-8366	(515) 256-4606	
KS	Department of Social and Rehabilitation Services of Kansas	(800) 766-9012	(785) 296-3981	
KY	Cabinet for Health Services of Kentucky	(800) 635-2570	(502) 564-4321	
LA	Louisiana Department of Health and Hospital	(888) 342-6207		(877) 252-2447
MW	Maine Department of Health and Human Services	(800) 977-6740	(207) 287-9202	
MD	Department of Health and Mental Hygiene	(800) 492-5231	(410) 767-5800	
MA	Office of Health and Human Services of Massachusetts	(800) 841-2900		
MI	Michigan Department Community Health	(800) 642-3195	(517) 373-3740	

State Medical Assistance Offices				
MN	Department of Human Services of Minnesota - MinnesotaCare	(800) 657-3739	(651) 431-2801	
MS	Office of the Governor of Mississippi	(800) 421-2408	(601) 359-6050	
MO	Department of Social Services of Missouri - MO HealthNet Division	(800) 392-2161	(573) 751-3425	
MT	Montana Department of Public Health & Human Services-Division of Child and Adult Health Resources	(800) 362-8312		
NE	Nebraska Department of Health and Human Services System	(800) 430-3244	(402) 471-3121	
NV	Nevada Department of Human Resources, Aging Division	(800) 992-0900	(775) 684-7200	
NH	New Hampshire Department of Health and Human Services	(800) 852-3345		
NJ	Department of Human Services of New Jersey	(800) 356-1561		(800) 356-1561
NM	Department of Human Services of New Mexico	(888) 997-2583	(505) 827-3100	(800) 432-6217
NY	New York State Department of Health	(800) 541-2831		
NC	North Carolina Department of Health and Human Services	(800) 662-7030	(919) 855-4400	
ND	Dept of Human Services of North Dakota - Medical Services	(800) 755-2604	(701) 328-2321	
OH	Department of Job and Family Services of Ohio - Ohio Health Plans	(800) 324-8680	(614) 644-0140	
OK	Health Care Authority of Oklahoma	(800) 522-0310	(405) 522-7171	
OR	Oregon Department of Human Services	(800) 527-5772	(503) 945-5772	
PA	Department of Public Welfare of Pennsylvania	(800) 692-7462		
RI	Department of Human Services of Rhode Island		(401) 462-5300	
SC	South Carolina Department of Health and Human Services	(888) 549-0820	(803) 898-2500	
SD	Department of Social Services of South Dakota	(800) 597-1603	(605) 773-3495	(800) 305-9673
TN	Bureau of TennCare	(866) 311-4287		
TX	Health and Human Services Commission of Texas	(877) 541-7905	(512) 424-6500	
UT	Utah Department of Health	(800) 662-9651	(801) 538-6155	(800) 662-9651
VT	Agency of Human Services of Vermont	(800) 250-8427	(802) 879-5900	
VA	Department of Medical Assistance Services		(804) 786-7933	

State Medical Assistance Offices				
WA	Health Care Authority (formerly - Department of Social and Health Services of Washington)	(800) 562-3022		
DC	DC Healthy Families and DC HealthCare Alliance - formerly (DC Healthy Family)	(800) 620-7802	(202) 639-4030	
WV	West Virginia Department of Health & Human Resources	(800) 642-8589	(304) 558-1700	
WI	Wisconsin Department of Health	(800) 362-3002	(608) 266-1865	
WY	Wyoming Department of Health	(866) 571-0944	(307) 777-7656	

State Health Insurance Assistance Program (SHIP)					
State	**Agency Name**	**Street Address**	**City/State**	**Zip**	**Phone Number**
AK	Alaska Department of Health and Social Services	P.O. Box 110601	Juneau, AK	99811	(907) 465-3030
AL	State Health Insurance Assistance Program (SHIP)	201 Monroe Street, RSA Tower Suite 350	Montgomery, AL	36130	(800) 243-5463
AR	Seniors Health Insurance Information Program (SHIIP)	1200 W. 3rd Street	Little Rock, AR	72201	(800) 224-6330
AZ	Arizona State Health Insurance Assistance Program (SHIP)	1789 W. Jefferson, #950A	Phoenix, AZ	85007	(800) 432-4040
CA	Health Insurance Counseling & Advocacy Program (HICAP)	3950 Industrial Blvd. Suite 500	Sacramento, CA	95691	(800) 434-0222
CO	Senior Health Insurance Assistance Program (SHIP)	1560 Broadway, Suite 850	Denver, CO	80202	(888) 696-7213
CT	Connecticut Program for Health Insurance Assistance, Outreach, Information & Referral Counseling and Elig. Screening (CHOICES)	25 Sigourney Street	Hartford, CT	06106	(800) 994-9422
DC	Health Insurance Counseling Project (HICP)	500 K Street, NE	Washington, DC	20002	(202) 724-5622
DE	ELDERinfo	841 Silver Lake Boulevard	Dover, DE	19904	(800) 336-9500

State Health Insurance Assistance Program (SHIP)					
FL	SHINE (Serving Health Insurance Needs of Elders)	4040 Esplanade Way	Tallahassee, FL	32399	(800) 963-5337
GA	Georgia Cares	2 Peachtree St., NW, Suite 9-210	Atlanta, GA	30303	(800) 669-8387
HI	Sage PLUS	250 S. Hotel St., 4th Floor	Honolulu, HI	96813	(888) 875-9229
IA	Senior Health Insurance Information Program (SHIIP)	330 Maple St.	Des Moines, IA	50319	(800) 351-4664
ID	Senior Health Insurance Benefits Advisors (SHIBA)	P.O. Box 83720	Boise, ID	83720	(800) 247-4422
IL	Senior Health Insurance Program (SHIP)	320 W. Washington Street, 4th Floor	Springfield, IL	62767	(800) 548-9034
IN	State Health Insurance Assistance Program (SHIP)	714 W. 53rd Street	Anderson, IN	46013	(800) 452-4800
KS	Senior Health Insurance Counseling for Kansas (SHICK)	503 S. Kansas	Topeka, KS	66603	(800) 860-5260
KY	State Health Insurance Assistance Program (SHIP)	275 East Main Street	Frankfort, KY	40621	(877) 293-7447
LA	Senior Health Insurance Information Program (SHIIP)	P.O. Box 94214	Baton Rouge, LA	70804	(800) 259-5301
MA	Serving Health Information Needs of Elders (SHINE)	1 Ashburton Place, 5th Floor	Boston, MA	02108	(800) 243-4636
MD	Senior Health Insurance Assistance Program	301 West Preston Street, Suite 1007	Baltimore, MD	21201	(800) 243-3425
ME	Maine State Health Insurance Assistance Program	11 State House Station, 442 Civic Center Drive	Augusta, ME	04333	(800) 262-2232
MI	Medicare/Medicaid Assistance Program (MMAP)	6105 West Street Joseph Hwy, Suite 204	Lansing, MI	48917	(800) 803-7174
MN	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line	540 Cedar Street, P.O. Box 64976	St. Paul, MN	55164	(800) 333-2433
MO	Community Leaders Assisting the Insured of MO (CLAIM)	200 N. Keene Street	Columbia, MO	65201	(800) 390-3330

State Health Insurance Assistance Program (SHIP)					
MS	MS Insurance Counseling and Assistance Program (MICAP)	750 N. State Street	Jackson, MS	39202	(800) 948-3090
MT	Montana Health Insurance Assistance Program (SHIP)	P.O. Box 4210 / 2030-11th Ave	Helena, MT	59604	(800) 551-3191
NC	Seniors' Health Insurance Information Program (SHIIP)	11 South Boylan Avenue	Raleigh, NC	27603	(800) 443-9354
ND	Senior Health Insurance Counseling Program (SHIC)	600 E. Blvd., Dept. 401	Bismarck, ND	58505	(888) 575-6611
NE	Nebraska Senior Health Insurance Information Program (SHIIP)	941 O Street, Suite 400	Lincoln, NE	68508	(800) 234-7119
NH	NH SHIP - ServiceLink Resource Center	129 Pleasant Street, Gallen State Office Park	Concord, NH	03301	(866) 634-9412
NJ	State Health Insurance Assistance Program (SHIP)	PO Box 360	Trenton, NJ	08625	(800) 792-8820
NM	New Mexico ADRC/ SHIP Benefits Counseling	2550 Cerrillos Rd	Santa Fe, NM	87505	(800) 432-2080
NV	State Health Insurance Advisory Program (SHIP)	1860 E. Sahara Avenue	Las Vegas, NV	89104	(800) 307-4444
NY	Health Insurance Information Counseling and Assistance Program (HIICAP)	2 Empire State Plaza, Agency Bldg. #2, 4th Floor	Albany, NY	12223	(800) 701-0501
OH	Ohio Senior Health Insurance Information Program (OSHIIP)	50 West Town Street, 3rd Floor-Suite 300	Columbus, OH	43215	(800) 686-1578
OK	Senior Health Insurance Counseling Program (SHIP)	5 Corporate Plaza, 3625 NW 56th Street, Suite 100	Oklahoma City, OK	73112	(800) 763-2828
OR	Senior Health Insurance Benefits Assistance (SHIBA)	350 Winter ST NE, Suite 330	Salem, OR	97309	(800) 722-4134
PA	APPRISE	555 Walnut St., 5th Floor	Harrisburg, PA	17101	(800) 783-7067
RI	Senior Health Insurance Program (SHIP)	74 West Road	Cranston, RI	02920	(401) 462-0510
SC	Insurance Counseling Assistance and Referrals for Elders (I-CARE)	1301 Gervais Street., Suite 350	Columbia, SC	29202	(800) 868-9095

State Health Insurance Assistance Program (SHIP)					
SD	Senior Health Information and Insurance Education (SHIINE)	700 Govenors Drive	Pierre, SD	57501	(800) 536-8197
TN	TN SHIP	502 Deaderick Street, 9th Floor	Nashville, TN	37243	(877) 801-0044
TX	Health Information, Counseling and Advocacy Program (HICAP)	701 W. 51st Street, MC: W352	Austin, TX	78751	(800) 252-9240
UT	Health Insurance Information Program (HIIP)	195 N 1950 W	Salt Lake City, UT	84116	(801) 538-3910
VA	Virginia Insurance Counseling and Assistance Project (VICAP)	1610 Forest Avenue, Suite 100	Richmond, VA,	23229	(800) 552-3402
VT	State Health Insurance and Assistance Program (SHIP)	481 Summer Street, Suite 101	St. Johnsbury, VT	05819	(800) 642-5119
WA	Statewide Health Insurance Benefits Advisors (SHIBA) Helpline	P.O. Box 40256	Olympia, WA	98504	(800) 562-6900
WI	Wisconsin SHIP (SHIP)	1 W. Wilson St., Rm. 450	Madison, WI	53707	(800) 242-1060
WV	West Virginia State Health Insurance Assistance Program (WV SHIP)	1900 Kanawha Blvd., East (Mail) 3rd Floor Town Ctr	Charleston, WV	25305	(877) 987-4463
WY	Wyoming State Health Insurance Information Program (WSHIIP)	106 W. Adams Avenue	Roverton, WY	82501	(800) 856-4398

Quality Improvement Organizations (QIO)					
State	**Agency Name**	**Street Address**	**City/State**	**Zip**	**Phone Number**
AK	Livanta BFCC-QIO Program	9090 Junction Drive, Suite 10	Annapolis Junction, MD	20701	(877) 588-1123
AL	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
AR	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
AZ	Livanta BFCC-QIO Program	9090 Junction Drive, Suite 10	Annapolis Junction, MD	20701	(877) 588-1123
CA	Livanta BFCC-QIO Program	9090 Junction Drive, Suite 10	Annapolis Junction, MD	20701	(877) 588-1123
CO	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504

Quality Improvement Organizations (QIO)					
CT	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
DC	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
DE	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
FL	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
GA	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
HI	Livanta BFCC-QIO Program	9090 Junction Drive, Suite 10	Annapolis Junction, MD	20701	(877) 588-1123
IA	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
ID	Livanta BFCC-QIO Program	9090 Junction Drive, Suite 10	Annapolis Junction, MD	20701	(877) 588-1123
IL	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
IN	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
KS	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
KY	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
LA	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
MA	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
MD	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
ME	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
MI	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
MN	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
MO	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
MS	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
MT	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504

Quality Improvement Organizations (QIO)					
NC	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
ND	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
NE	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
NH	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
NJ	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
NM	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
NV	Livanta BFCC-QIO Program	9090 Junction Drive, Suite 10	Annapolis Junction, MD	20701	(877) 588-1123
NY	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
OH	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
OK	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
OR	Livanta BFCC-QIO Program	9090 Junction Drive, Suite 10	Annapolis Junction, MD	20701	(877) 588-1123
PA	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
RI	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
SC	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
SD	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
TN	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
TX	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
UT	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504
VA	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
VT	Livanta BFCC_QIO Program	9090 Junction Dr, Suite 10	Annapolis Junction, MD	20701	(866) 815-5440
WA	Livanta BFCC-QIO Program	9090 Junction Drive, Suite 10	Annapolis Junction, MD	20701	(877) 588-1123

Quality Improvement Organizations (QIO)					
WI	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(855) 408-8557
WV	KEPRO	5201 W. Kennedy Blvd, Suite 900	Tampa, FL	33609	(844) 455-8708
WY	KEPRO	5700 Lombardo Center Dr, Suite 100	Seven Hills, OH	44131	(844) 430-9504

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