



Medicare Part D Prescription Drug Coverage

Preferred Provider Organization



Evidence of Coverage Medicare Prescription Drug Plan (PDP)

Effective January 1, 2014 - December 31, 2014

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

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of PERSCare sponsored by the California Public Employees' Retirement System (CalPERS)

This booklet gives you the details about your Medicare prescription drug coverage from **January 1, 2014 - December 31, 2014**. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.** This document describes your primary Medicare Part D Benefit. You also have supplemental prescription drug coverage provided by CalPERS which is described in your Supplement to Original Medicare Plan Evidence of Coverage booklet or call Customer Care at 1-855-479-3660.

This plan, PERSCare Medicare Part D Prescription Drug Plan (PERSCare Medicare Part D PDP) sponsored by CalPERS, is offered by *CVS Caremark*. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means *CVS Caremark*. When it says “plan” or “our plan,” it means *PERSCare Medicare Part D PDP*.)

CalPERS has implemented an Employer Group Waiver Plan (EGWP) for Medicare-eligible retirees effective January 1, 2014. This plan is administered by CVS/Caremark. This means that Medicare-eligible retirees and/or dependents have been enrolled in a Group Medicare Part D Plan. CalPERS, through PERSCare, is providing you a pharmacy plan, which supplements the Part D Plan so you have the same level of benefits as before with your PERSCare Plan.

This information is available for free in other languages. Please contact our Customer Care number at 1-855-479-3660 for additional information. (TTY users should call 1-866-236-1069.) Hours are 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers (phone numbers are printed on the last page of this booklet).

Esta información está disponible gratuitamente en otros idiomas. Comuníquese con nuestro Servicio al Cliente, al 1-855-479-3660 para obtener información adicional. (Los usuarios de teléfono de texto (TTY) deben llamar al 1-866-236-1069.) El horario es las 24 horas al día, los 7 días de la semana. El Servicio al Cliente también tiene servicios gratuitos de interpretación disponibles para personas que no hablan inglés (los números telefónicos se encuentran en la contraportada de este folleto).

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

Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2015.

2014 Evidence of Coverage

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SECTION 1 Introduction

Section 1.1	You are enrolled in PERSCare Medicare Part D PDP, which is a Medicare Prescription Drug Plan
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Please note: this prescription coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than PERSCare Medicare Part D PDP, you cannot be enrolled in the PERSCare Supplement to Original Medicare Plan (PERSCare Supplemental Plan).

There are different types of Medicare plans. PERSCare Medicare Part D PDP administered by CVS Caremark is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?
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This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, PERSCare Medicare Part D PDP sponsored by CalPERS, is offered by *CVS Caremark*. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means *CVS Caremark*. When it says “plan” or “our plan,” it means PERSCare Medicare Part D PDP.)

The word “coverage” and “covered drugs” refers to the prescription drug coverage available to you as a member of PERSCare Medicare Part D PDP.

Section 1.3	What does this Chapter tell you?
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Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan’s service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4	What if you are new to PERSCare Medicare Part D PDP?
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If you are a new member, then it’s 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 Customer Care (phone numbers are printed on the last page of this booklet).

Section 1.5 Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in PERSCare Medicare Part D PDP between January 1, 2014 and December 31, 2014.

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 PERSCare Medicare Part D PDP after December 31, 2014. We can also choose to stop offering the plan, or offer it in a different service area, after December 31, 2014.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- 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)
- -- and -- you have Medicare Part A or Medicare Part B (or you have both Part A and Part B)

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

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

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), 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 PERSCare Medicare Part D PDP

Medicare is a Federal program and PERSCare Medicare Part D PDP is available only to CalPERS members who reside in the United States or its territories. To remain a member of our plan, you must reside in the United States or its territories and not be incarcerated. Please Note: If you use a Post Office Box, you will need to provide proof that you live in our service area.

If you plan to move out of the service area, please contact CalPERS and Customer Care (phone numbers are printed on the last page of this booklet). When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

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

SECTION 3 What other materials will you get from us?

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

While you are a member of our plan, you must use your membership card for our plan for prescription drugs you get at network pharmacies.

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

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

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

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

What are “network pharmacies”?

Our *Pharmacy Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

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

The *Pharmacy Directory* will also tell you which of the pharmacies in our network are the “preferred” network pharmacies. Preferred pharmacies may have lower cost sharing for covered drugs compared to other network pharmacies.

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

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

The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which Part D and CalPERS supplemental prescription drugs are covered by PERSCare

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

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

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

Section 3.4 The *Explanation of Benefits* (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs

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

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about the *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 Customer Care (phone numbers are printed on the last page of this booklet).

SECTION 4 Your monthly premium for PERSCare Medicare Part D PDP

Section 4.1 How much is your plan premium?
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CalPERS is responsible for paying any monthly plan premium, if applicable, to the plan. Please contact CalPERS for information about your plan premium.

In some situations, your plan premium could be less

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

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

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

In some situations, your plan premium could be more than the amount listed. These situations are described below. Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn’t have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) For these members, the late enrollment penalty is added to the plan’s monthly premium. In that case, their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.

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

- If you have a late enrollment penalty, it is part of your plan premium. If you do not pay the part of your premium that is the late enrollment penalty, you could be disenrolled for failure to pay your plan premium. Therefore, to avoid disenrollment, make sure your late enrollment penalty is paid.
- If you have a late enrollment penalty, you will receive a monthly invoice from CVS Caremark. If you do not pay the monthly late enrollment penalty premium you could be disenrolled for failure to pay your plan premium. Therefore, to avoid disenrollment, make sure your late enrollment penalty is paid.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. Some plan members (those who aren't 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. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount directly to the government (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, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 4, Section 10 of this booklet. You can also visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2014* gives information about the Medicare premiums in the section called “**2014 Medicare Costs.**” This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2014* from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

SECTION 5 Please keep your plan membership record up to date

Section 5.1	How to help make sure that we have accurate information about you
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Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

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

Let us know about these changes:

- Changes to your name, 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 your designated responsible party (such as a caregiver) changes

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

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

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's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see the end of this chapter.)

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

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

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?
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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 size of the employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you’re under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you’re over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

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

Chapter 2. Important phone numbers and resources

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

How to contact our plan's Customer Care

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

Customer Care	
CALL	1-855-479-3660 Calls to this number are free. 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	1-866-236-1069 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	45 Great Circle Rd. Nashville, TN 37228
WEBSITE	http://www.caremark.com/calpers

How to contact us 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 Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

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

You have specific coverage request rules and appeal rights for drugs covered by your CalPERS supplemental coverage. Your coverage request rules and appeal rights can be found beginning on page 125.

Coverage Decisions and Appeals for Part D Prescription Drugs	
CALL	1-855-479-3660 Calls to this number are free. 24 hours a day. 7 days a week.
TTY	1-866-236-1063 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day. 7 days a week.
FAX	1-855-633-7673
WRITE	CVS Caremark Medicare Part D Appeals Department MC109 P.O. Box 52000 Phoenix, AZ 85072-2000
WEBSITE	http://www.caremark.com/calpers

How to contact us when you are making a complaint about our Part D prescription drugs

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

Complaints about Part D prescription drugs	
CALL	1-855-479-3660 Calls to this number are free. 24 hours a day. 7 days a week.
TTY	1-866-236-1063 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day. 7 days a week.

FAX	1-866-217-3353
WRITE	CVS Caremark Medicare Part D - Grievances P.O. Box 53991, MC 121 Phoenix, AZ 85072-3991
MEDICARE WEBSITE	You can submit a complaint about PERSCare Medicare Part D PDP administered by CVS Caremark directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx .

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

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

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

Payment Requests	
CALL	1-855-479-3660 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	866-236-1069 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Med D Paper Claims P.O. Box 52066 Phoenix, Arizona 85072-2066
WEBSITE	http://www.caremark.com/calpers

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

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

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

Medicare	
CALL	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>http://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information.• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about PERSCare Medicare Part D PDP.

- **Tell Medicare about your complaint:** You can submit about PERSCare Medicare Part D PDP directly to Medicare. To submit a complaint, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

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

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

HICAP (California'sSHIP)	
CALL	(800) 434-0222 Calls to this number are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	HICAP 5380 Elvas Avenue, Suite 221 Sacramento, CA 95819
WEBSITE	www.cahealthadvocates.org

If you live outside of California, you can contact customer care at 1-855-479-3660 for assistance finding your state's SHIP.

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 in each state. Please call Customer Care for contact information of the Quality Improvement Organization in your state. (Customer Care phone numbers are printed on the last page of this booklet.)

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

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

HSAG (California's Quality Improvement Organization)	
CALL	(800) 841-1602 Calls to this number are free. Available 24 hours a day, 7 days a week.
TTY	(800) 881-5980 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Health Services Advisory Group, Inc. Attn: Beneficiary Protection 700 North Brand Boulevard, Suite 370 Glendale, CA 91203
WEBSITE	www.hsag.com

SECTION 5 Social Security

Social Security 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 coverage because they have a higher income. If you got 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.

Social Security	
CALL	(800)-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	(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 to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

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

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

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums. (Some people with QMB 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 and its programs, contact your local Medi-Cal Office, please call the California Department of Healthcare Services or contact Customer Care. To find out more about other state Medicaid programs contact Customer Care.

California Department of Healthcare Services	
CALL	(800)-541-5555
TTY	(800) 735-2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	PO Box 997413 MS4400 Sacramento, CA 95899-7413
WEBSITE	www.dhcs.ca.gov

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

Medicare's "Extra Help" Program

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

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

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

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

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

- PERSCare Medicare Part D PDP will accept any of the following documents as evidence:
 - A copy of your Medicaid card which includes your name and eligibility date during the period for which you believe you qualified for Extra Help;
 - Details of any call you made to verify your Medicaid status, including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the state staff person who verified your Medicaid status during the discrepant period;
 - A copy of a state document that confirms your active Medicaid status during the discrepant period;
 - A print out from the State electronic enrollment file showing your Medicaid status during the discrepant period;
 - A screen-print from the State’s Medicaid systems showing your Medicaid status during the discrepant period;
 - Other documentation provided by the State showing your Medicaid status during the discrepant period;
 - A letter from the Social Security Administration (SSA) showing that the individual receives Supplemental Security Income (SSI); or,
 - An “Important Information” letter from SSA confirming that the beneficiary is “automatically eligible for extra help.”
- Documentation from the state or SSA showing your low-income subsidy level is the preferred evidence of your proper cost sharing level. If you cannot provide the documentation and need assistance or would like additional information, contact Customer Care, 24 hours a day, 7 days a week at 1-855-479-3660. TTY users should call 1-866-236-1069.
- For beneficiaries that are institutionalized and qualify for zero cost-sharing, the following documents will be accepted as evidence of your proper cost sharing level:
 - A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
 - A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
 - A screen print from the State’s Medicaid systems showing that individual’s institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Care if you have questions (phone numbers are printed on the last page of this booklet).

Medicare Coverage Gap Discount Program

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

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

SECTION 8 How to contact the Railroad Retirement Board

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

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

Railroad Retirement Board	
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 <i>not</i> free.
WEBSITE	www.rrb.gov

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group other than CalPERS, call the employer/union benefits administrator or Customer Care if you have any questions. You can ask about your (or your spouse's) employer or retiree health or drug benefits, premiums, or enrollment period. (Phone numbers for Customer Care are printed on the last page of this booklet.)

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

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

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

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

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

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

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

The two examples of drugs described above are covered by Original Medicare. The medical coverage provided by your employer group or union may cover a supply of these drugs.

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

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

- You must have a provider (a doctor or other prescriber) write your prescription.
- In most circumstances, you must use a network pharmacy to fill your prescription or you must submit a paper claim form to us. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2	Fill your prescription at a network pharmacy or through the plan's mail-order service
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Section 2.1	To have your prescription covered, use a network pharmacy
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In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

Our network includes preferred pharmacies. You may go to either preferred network pharmacies or other network pharmacies to receive your covered prescription drugs. Your costs may be less at preferred pharmacies.

Change your 34-day refills to 90-day supplies at Preferred Pharmacies.

If you're currently taking any long-term medicines*, you can save money by asking your physician to change your 34-day refills to lower-cost 90-day supplies. Filling one 90-day supply can sometimes cost you less than three 34-day refills of the same prescription. Refill at a CVS/pharmacy or with CVS Caremark Mail Service Pharmacy and have a 90-day supply of your long term medicines shipped to your home.

Choose from two 90-day refill options for the same low price.

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

Option 2: Refill with CVS Caremark Mail Service Pharmacy. Have a 90-day supply of your long term medicines shipped to your home or office.

*Long-term medicines are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

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

You may go to any of our network pharmacies. However, your costs may be lower for your covered drugs if you use a preferred network pharmacy rather than other pharmacies within the network. The *Pharmacy Directory* will tell you which of the pharmacies in our network are preferred 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 either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

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

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

What if you need a specialized pharmacy?

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

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

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

Section 2.3 Using the plan's mail-order services

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

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

To get order forms and information about filling your prescriptions by mail, visit our website (<http://www.caremark.com/calpers>) or contact Customer Care.

Usually a mail-order pharmacy order will get to you in no more than 10 days. If the mail-order pharmacy expects a delay of more than 10 days, they will contact you and help you decide whether to wait for the medication, cancel the mail order, or fill the prescription at a local pharmacy. If your order does not reach you within 10 days, you may contact Customer Care.

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

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply 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.)

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

Section 2.5	When can you use a pharmacy that is not in the plan's network?
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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).
- The drug is administered in your doctor's office.
- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.

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

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

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5 in the Evidence of Coverage explains how to ask the plan to pay you back.)

If you must 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. (Chapter 5 in the *Evidence of Coverage* explains how to ask the plan to pay you back.)

If you must use an out-of-network pharmacy, we will reimburse you our network contracted rate for a one-month supply minus your cost share amount for the drug. You must submit a paper claim in order to be reimbursed. (Chapter 5 in the *Evidence of Coverage* explains how to ask the plan to pay you back.)

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

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

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

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

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

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

"Medically accepted indication" is a use of a drug that is either:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- or -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

PERSCare Medicare Part D PDP does not cover drugs 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 that are not covered under Medicare Part D, including Diabetic supplies, prescription Vitamins, some Barbiturates, some Benzodiazepines, prescription Cough and Cold medications, Anorexients, Cosmetic, and Sexual or Erectile Dysfunction drugs.

The Drug List includes both brand name and generic drugs

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

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs.
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2	There are three “cost-sharing tiers” for drugs on the Drug List
--------------------	--

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

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

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

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

Please note: CalPERS provides secondary coverage that may differ in structure from the primary benefit and also cover additional medications. There may be instances where your cost share may be more or less when it is paid by the secondary. If you are unsure about the cost share on the secondary or which drugs may or may not be covered, please call Customer Care to verify drug coverage.

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

You have three ways to find out:

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

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

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

Section 4.2 What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available

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

Getting plan approval in advance (Prior Authorization)

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

Trying a different drug first (Step Therapy)

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

Quantity limits

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

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

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

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered
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Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. 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, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
 - In some cases, you may want us to waive the restriction for you. For example, you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
 - For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
 - In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or, you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **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'd like it to be covered. Your options depend on what type of problem you have:

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

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are things you can do:

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

You may be able to get a temporary supply

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

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

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

- The drug you have been taking is **no longer on the plan's Drug List**
- -- or -- the drug you have been taking is **now restricted in some way**.

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

- **For those members who were in the plan last year and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of the plan year**. This temporary supply will be for a maximum of 34-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 aren't 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 membership** in the plan. This temporary supply will be for a maximum of 34-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 a new member and a resident in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 34-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 34-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 will cover a one-time temporary supply for up to 34 days (or 34 days if you are a long-term care resident) from a network pharmacy. During this period, 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 Customer Care (phone numbers are printed on the last page of this booklet).

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

You can change to another drug

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

You can ask for an exception

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

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

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

Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?
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If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

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

You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 7 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: Preferred Generic Drugs, Tier 2: Preferred Brand Drugs.

Preferred and Non-Preferred Brand-Name Drugs

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

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

Section 6.1	The Drug List can change during the year
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

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

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

Section 6.2	What happens if coverage changes for a drug you are taking?
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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's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

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

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

If any of these changes happens for a drug you are taking, then the change won't 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 won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

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

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

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

CalPERS has elected to cover certain drugs not covered under Medicare Part D as described and dispensed as part of a supplemental benefit. These are not subject to the appeals and exceptions process below. The coverage request rules and appeal process for your CalPERS supplemental coverage begins on page 125 or you can contact Customer Care for any questions regarding your supplemental benefit.

Section 7.1 Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

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

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.

- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
 - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, 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, by law, these categories of drugs are not covered by Medicare drug plans:

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

PERSCare Medicare Part D PDP offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan. 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, Section 7 of this booklet.)

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

1. Non-medical therapeutic devices, durable medical equipment, appliances and supplies, including support garments, even if prescribed by a physician, regardless of their intended use. *
2. Drugs not approved by the U.S. Food and Drug Administration (FDA)
3. Off label use of FDA approved drugs**, if determined inappropriate through CVS Caremark's Coverage Management Programs.
4. Any quantity of dispensed Medications that is determined inappropriate as determined by the FDA or through CVS Caremark's coverage management programs.

5. Drugs or medicines obtainable without a Prescriber's Prescription, often called Over-the-Counter (OTC) Drugs or Behind-the-Counter (BTC) Drugs, except insulin, diabetic test strips and lancets, and Plan B.
6. Dietary and herbal supplements, minerals, health aids, homeopathics, any product containing a medical food, and any vitamins whether available over the counter or by Prescription (e.g., prenatal vitamins, multi-vitamins, and pediatric vitamins), except Prescriptions for single agent vitamin D, vitamin K and folic acid.
7. A Prescription Drug that has an over-the-counter alternative.
8. Anorexiant and appetite suppressants or any other anti-obesity Drugs.
9. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses).
10. Charges for the purchase of blood or blood plasma.
11. Hypodermic needles and syringes, except as required for the administration of a covered Drug.
12. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
13. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any drug or Medication prescribed for experimental indications.
14. Any Drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.
15. Any Drugs or Medications which are not legally available for sale within the United States.
16. Any charges for injectable immunization agents (except when administered at a Participating Pharmacy), desensitization products or allergy serum, or biological sera, including the administration thereof. *
17. Professional charges for the administration of Prescription Drugs or injectable insulin. *
18. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a hospital or skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility. *
19. Drugs and Medications dispensed or administered in an outpatient setting (e.g., injectable Medications), including, but not limited to, outpatient hospital facilities, and services in the Member's home provided by Home Health Agencies and Home Infusion Therapy Providers. *
20. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or Medication furnished by any other drug or medical services for which no charge is made to the Plan Member.
21. Any quantity of dispensed Drugs or medicines which exceeds a thirty (34) day supply at any one time, unless obtained through CVS Caremark Mail Service or the Maintenance Choice® program. Prescriptions filled using CVS Caremark Mail Service or the Maintenance Choice® program are limited to a maximum ninety (90) day supply of covered drugs or medicines as prescribed by a Prescriber. Specialty Medications are limited up to a 34 day supply.

22. Refills of any Prescription in excess of the number of refills specified by a Prescriber.
23. Any drugs or medicines dispensed more than one (1) year following the date of the Prescriber's Prescription Order.
24. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a Non-Participating Pharmacy, or the CVS Caremark Mail Service program. .
25. Compounded Medications if: (1) there is a medically appropriate formulary alternative, or (2) the compounded Medication contains any ingredient not approved by the FDA. Compounded Medications that do not include at least one covered Prescription Drug will not be covered.
26. Replacement of lost, stolen, or destroyed Prescription Drugs.

NOTE: While not covered under this Plan, items marked by an asterisk (*) may be covered by your Health Plan. See your Health Plan's EOC for more information.

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

Services Covered By Other Benefits

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

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

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

Section 8.1 Show your membership card

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

Section 8.2	What if you don't have your membership card with you?
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If you don't have your plan membership card with you when you fill your prescription, call Customer Care the plan to get the necessary information.

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

SECTION 9	Part D drug coverage in special situations
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Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?
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If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

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

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

Section 9.2	What if you're a resident in a long-term care facility?
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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.

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

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

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of a 34-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.

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

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

Section 9.3	What if you are taking drugs covered by Original Medicare?
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Your enrollment in PERSCare Medicare Part D PDP doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through PERSCare Medicare Part D PDP in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or PERSCare Medicare Part D PDP for the drug.

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

Section 9.4	What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?
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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 is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn’t get this notice, or if you can’t find it, contact your Medigap insurance company and ask for another copy.

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

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

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

Special note about “creditable coverage”

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is “creditable” and the choices you have for drug coverage.

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

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn’t 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 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

Section 10.2 Programs to help members manage their medications

We have programs that can help 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.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs 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.

One program is called a Medication Therapy Management (MTM) program. Some Members who take several medications for different medical conditions may qualify. 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, or any problems you're having. You'll 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'll also get a personal medication list that will include all the medications you're taking and why you take them. If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Care (phone numbers are printed on the last page of this booklet).

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

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

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

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

Section 1.1	Use this chapter together with other materials that explain your drug coverage
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This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Original Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

As a member of PERSCare Medicare Part D PDP sponsored by CalPERS, some excluded drugs may be covered since your plan has supplemental drug coverage. Please refer back to Chapter 3 to find more information about the type of coverage you have with CalPERS.

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

- **The plan’s *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.
 - 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 Customer Care (phone numbers are printed on the last page of this booklet). You can also find the Drug List on our website at <http://www.caremark.com/calpers>. The Drug List on the website is always the most current.
- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan and which drugs may be covered under CalPERS supplemental coverage.
- **The plan's *Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you how you can use the plan's mail-order service to get certain types of drugs. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three month's supply).

Section 1.2	Types of out-of-pocket costs you may pay for covered drugs.
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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
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Section 2.1	What are the drug payment stages for PERSCare Medicare Part D PDP members?
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As shown in the table below, there are “drug payment stages” for your prescription drug coverage under PERSCare Medicare Part D PDP. How much you pay for a drug depends on your benefit plan. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 <i>Initial Coverage Stage</i>	Stage 2 <i>Coverage Gap Stage</i>	Stage 3 <i>Catastrophic Coverage Stage</i>	<i>MOOP Stage</i>
<p>You begin in this payment stage when you fill your first prescription of the year.</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$2850.</p> <p>(Details are in Section 4 of this chapter.)</p>	<p>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 stage.</p> <p>You will stay in the Coverage Gap stage until your out-of-pocket costs reach \$4550. This is the amount you must pay out-of-pocket to leave the Coverage Gap stage and qualify for Catastrophic Coverage.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the plan year (through 2014).</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>After you reach your maximum out-of-pocket costs of \$1000, then the plan will pay the rest of your annual drug costs.</p> <p>*Restrictions may apply.</p>

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

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

Section 3.1 We send you a monthly report called the “Explanation of Benefits” (the “EOB”)

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

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

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

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since 2014.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Any supplemental drug coverage you receive from your employer group or union will not show up on your *Explanation of Benefits*.**

Section 3.2	Help us keep our information about your drug payments up to date
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

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

- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Care (phone numbers are printed on the last page of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 4.1 What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has three Cost-Sharing Tiers

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

- **Cost-Sharing Tier 1: Generic Drugs**
- **Cost-Sharing Tier 2: Preferred Brand Drugs**
- **Cost-Sharing Tier 3: Non-Preferred Brand Drugs**

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

Your pharmacy choices

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

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

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

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

Section 4.2 A table that shows your costs for a supply of a drug

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

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

As shown in the 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 5 for information about when we will cover a prescription filled at an out-of-network pharmacy. If you go to an out-of-network or you must submit a paper claim form to us.

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

Before your \$1000 Maximum Out-of-Pocket is met, your cost sharing amounts will be:		
	Preferred Network Pharmacy	Network pharmacy
Generic Drug	You pay \$5 per prescription. (Up to a 34-day supply)	You pay \$15 per prescription. (Up to a 34-day supply)
Preferred Brand Name Drug	You pay \$20 per prescription. (Up to a 34-day supply)	You pay \$60 per prescription. (Up to a 34-day supply)
Non-Preferred Brand Name Drug	You pay \$50 per prescription. (Up to a 34-day supply)	You pay \$150 per prescription. (Up to a 34-day supply)

Section 4.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, 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 your 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's an example*: Let's say the copay for your drug for a full month's supply (a 34-day supply) is \$30. This means that the amount you pay per day for your drug is \$1. If you receive a 7 days' supply of the drug, your payment will be \$1 per day multiplied by 7 days, for a total payment of \$7.
 - You should not have to pay more per day just because you begin with less than a month's supply. Let's go back to the example above. Let's 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.
 - *Dollar amounts used in this example are for illustrative purposes only and do not reflect your actual copayments.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

Section 4.4	A table that shows your costs for a long-term supply of a drug
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For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3.)

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

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

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

Before your \$1,000 Maximum Out-of-Pocket is met, your cost sharing amounts will be:			
	Network pharmacy	Preferred CVS/pharmacy	The plan's mail-order service
Generic Drug	<i>You pay \$5 per 34 day prescription.</i> <i>You pay \$10 per 60 day prescription.</i> <i>You pay \$15 per 90 day prescription.</i>	<i>You pay \$10 per 90 day prescription.</i> <i>(Up to a 90-day supply)</i>	<i>You pay \$10 per 90 day prescription.</i> <i>(Up to a 90-day supply)</i>
Preferred Brand Name Drug	<i>You pay \$20 per 34 day prescription.</i> <i>You pay \$40 per 60 day prescription.</i> <i>You pay \$60 per 90 day prescription.</i>	<i>You pay \$40 per 90 day prescription.</i> <i>(Up to a 90-day supply)</i>	<i>You pay \$40 per 90 day prescription.</i> <i>(Up to a 90-day supply)</i>
Non-Preferred Brand Name Drug	<i>You pay \$50 per 34 day prescription.</i> <i>You pay \$100 per 60 day prescription.</i> <i>You pay \$150 per 90 day prescription.</i>	<i>You pay \$100 per 90 day prescription.</i> <i>(Up to a 90-day supply)</i>	<i>You pay \$100 per 90 day prescription.</i> <i>(Up to a 90-day supply)</i>

Section 4.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2850

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the \$2850 **limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what the 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. (See Section 5.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2014, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

PERSCare Medicare Part D PDP offers additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. To find out which drugs our plan covers, please call Customer Care.

The *Explanation of Benefits* (EOB) 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 \$2850 limit in a year.

We will let you know if you reach this \$2850 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

SECTION 5 During the Coverage Gap Stage, the plan provides some drug coverage

Section 5.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4550
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CalPERS provides supplemental prescription drug coverage for you during the Coverage Gap phase. The plan continues to cover your drugs at the applicable copayment until you qualify for the Catastrophic Stage. For more information please refer your Supplement to Original Medicare Plan Evidence of Coverage booklet or call Customer Care at 1-855-479-3660.

Section 5.2 How Medicare calculates your out-of-pocket costs for prescription drugs

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

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

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

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

It matters who pays:

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

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$4550 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

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

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

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

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

- **We will help you.** The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4550 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.

Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 6 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 6.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your true out-of-pocket costs have reached the \$4550 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.

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

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

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

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

SECTION 7 During the Maximum out-of-Pocket Costs (MOOP) Stage, the plan will pay the rest of your annual costs

Section 7.1 Maximum out-of-pocket costs (MOOP)
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Maximum out-of-pocket Costs (MOOP) – The most a person will pay in a year for copays/coinsurance for covered benefits. This amount can vary by employer group/union.

After you reach your maximum out-of-pocket costs of \$1000, then CalPERS will pay the rest of your annual drug costs.

The following copayments **do not** count towards the out- of-pocket maximum:

- 50% coinsurance for sexual or erectile dysfunction drugs
- Non-Preferred Brand Name copayments
- Member Pays the Difference copay differential
- Partial Waiver of Non-Preferred Brand Name copayments

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 Part D vaccine medication itself and for the cost of giving you the vaccination shot
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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 Part D vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs*.
 - Other vaccines are considered medical benefits. They are covered under Original Medicare.
- 2. Where you get the vaccine.**
- 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 Part D vaccination shot.

Situation 1: You buy the vaccine at the pharmacy and you get your Part D 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 5 of this booklet (*Asking the plan to pay its share of the costs for covered drugs*).
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the 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 5 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Section 8.2	You may want to call us at Customer Care before you get a vaccination
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The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Care whenever you are planning to get a vaccination. (Phone numbers for Customer Care are printed on the last page of this booklet).

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

SECTION 9 Do you have to pay the Part D “late enrollment penalty”?

Section 9.1 What is the Part D “late enrollment penalty”?

Note: If you receive “Extra Help” from Medicare to pay for your prescription drugs, 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.

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 for this drug coverage or you experienced a continuous period of 63 days or more when you didn’t have creditable prescription drug coverage. (“Creditable prescription drug coverage” is coverage that meets Medicare’s minimum standards since it is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

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

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

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

Section 9.2 How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have credible prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn’t have creditable coverage.

- For example, let's say you decide to wait 14 months before you join a Medicare Part D plan. That would mean you have 14 months without coverage. You multiply your total uncovered months by the 1% penalty 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 2013, this average premium amount was \$31.17. This amount may change for 2014.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times \$31.17, which equals \$4.36. This rounds to \$4.40. 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 don't 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
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Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this **"creditable drug coverage."** Please note:
 - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- Please note: If you receive a “certificate of creditable coverage” when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had “creditable” prescription drug coverage that expected to pay as much as Medicare’s standard prescription drug plan pays.
- The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, please look in your *Medicare & You 2014* 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?
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If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Care to find out more about how to do this (phone numbers are printed on the last page of this booklet).

Important: Do not stop paying your late enrollment penalty while you’re waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 10	Do you have to pay an extra Part D amount because of your income?
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Section 10.1	Who pays an extra Part D amount because of income?
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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 \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above 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, Social Security, 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 isn’t enough to cover the extra amount owed. If your benefit check isn’t enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 10.2 How much is the extra Part D amount?

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

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

If you filed an individual tax return and your income in 2012 was:	If you were married but filed a separate tax return and your income in 2012 was:	If you filed a joint tax return and your income in 2012 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	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$12.10
Greater than \$107,000 and less than or equal to \$160,000		Greater than \$214,000 and less than or equal to \$320,000	\$31.10
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$50.20
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$69.30

Section 10.3	What can you do if you disagree about paying an extra Part D amount?
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If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at (800) 772-1213 (TTY 1-800-325-0778).

Section 10.4	What happens if you do not pay the extra Part D amount?
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The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

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

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

Section 1.1	If you pay the plan's share of the cost of your covered drugs, you can ask PERSCare Medicare Part D PDP for payment
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Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

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

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

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

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

If you use an out of network pharmacy, we will reimburse you our network contracted rate minus your cost share amount for the drug. You must submit a paper claim in order to be reimbursed.

2. When you pay the full cost for a prescription because you don't have your plan membership card with you

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

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

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

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

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

4. If you are retroactively enrolled in our plan

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

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

- Please call Customer Care for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Care are printed on the last page of this booklet.)
- Ensure you provide this information no later than three (3) years from the date of service. Claims submitted after that date may not be processed. If you need to request an appeal on your denied paper claim, you must submit that request (with any representative forms) within 60 days from the date of the notice of the coverage determination (i.e. the date printed or written on the notice).

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

SECTION 2 How to ask PERSCare Medicare Part D PDP to pay you back

Section 2.1	How and where to send PERSCare Medicare Part D PDP your request for payment
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Send us your request for payment, along with your receipt documenting the payment you have made. It's 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 don't have to use the form, but it's helpful for our plan to process the information faster.
- Either download a copy of the form from our website (<http://www.caremark.com/calpers>) or call Customer Care and ask for the form. (Phone numbers are printed on the last page of this booklet.)

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

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

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

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

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

Section 3.1	The plan will check to see whether PERSCare Medicare Part D PDP should cover the drug and how much PERSCare Medicare Part D PDP owes
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

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

Section 3.2	If the plan tells you that PERSCare Medicare Part D PDP will not pay for all or part of the drug, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

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

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

Section 4.1	In some cases, you should send copies of your receipts to the plan to help track your out-of-pocket drug costs
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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 is a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

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

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

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

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

Chapter 6. Your rights and responsibilities

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

Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Customer Care (phone numbers are printed on the last page of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

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

Section 1.2	We must treat you with fairness and respect at all times
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** (800) 368-1019 TTY (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 at Customer Care (phone numbers are printed on the last page of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

Section 1.3	We must ensure that you get timely access to your covered drugs
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As a member of our plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do.

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

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

NOTICE OF PRIVACY PRACTICES

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

Effective August 2009

1. OUR PRIVACY PRACTICES

CVS Caremark is committed to protecting the privacy and confidentiality of your personal information in accordance with law and our own company policies. This notice describes our privacy practices for both current and former enrollees. It explains how we use health information about you and when we may share that health information with others. It also informs you about your rights with respect to your health information and how you may exercise these rights. We are required by law to maintain the privacy of your health information and to send you a copy of this notice so that you are aware of how we maintain the privacy of your health information.

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

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

2. HEALTH CARE INFORMATION MAINTAINED AT CVS Caremark

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

- Information provided on enrollment forms, surveys and our website, such as your name, address and date of birth
- Information from pharmacies, physicians or other health care providers, long term care facilities or health plans
- Information provided by your employer or other plan sponsor regarding any group plan that you may have

- Information we obtain from your transactions with us, our affiliates, or others, such as health care providers; Information we receive from consumer or medical reporting agencies or others, such as state regulators and law enforcement agencies

3. HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

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

For Treatment

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

For Payment

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

For Health Care Operations

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

To Make Health-Related Communications to You

We may use and disclose your health information in order to inform you about health-related products and services. For example, we may contact you:

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

To CalPERS

Under certain circumstances, we may share limited health information about you with CalPERS, the sponsor of the group health plan through which you receive health benefits. For example, we may share information with CalPERS related to your enrollment or disenrollment in the plan, as well as summary health information to enable CalPERS to obtain bids from other health plans.

We may also share information for plan administration purposes if certain protections are included in the plan document.

For the Treatment, Payment, and Health Care Operations of Other Health Plans or Health Care Providers

We may disclose your health information for another health plan or health care provider's treatment, payment, and, if certain conditions are met, health care operations. For example, we may disclose your health information when it would facilitate payment for services under another health plan.

OTHER USES AND DISCLOSURES

We may also make the following types of uses and disclosure of your health information:

- To a friend or family member who is involved in your care or to someone who helps pay for your care if you are not present or do not object, and we believe it is in your best interests in the circumstances. This includes disclosure to an entity assisting in a disaster relief effort so that your family or those involved in your care can be notified about your condition, status or location.
- To third parties performing any business functions for us, provided the third party agrees to protect and safeguard your health information, and to use and disclose it only as permitted by us.
- To conduct medical research, provided that additional measures are taken to protect your privacy.
- To comply with state and federal laws that require the release of your health information.
- To public health authorities or others acting under their authority for purposes such as reporting adverse reactions to medications or problems with medical products, or if we believe there is a serious threat to your health and safety or that of others.
- To health oversight agencies for activities such as audits, inspections, licensure and peer review activities.
- For legal or administrative proceedings, such as pursuant to a court order, search warrant or subpoena.
- To support law enforcement activities; for example, we may provide health information to law enforcement agents for the purpose of identifying or locating a fugitive, material witness or missing person.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- To report information to a government authority regarding child abuse, neglect or domestic violence.
- To share information with a coroner or medical examiner as authorized by law, or with funeral directors, as necessary to carry out their duties.
- To use or share information for procurement, banking or transplantation of organs, eyes or tissues.
- To report information regarding job-related injuries as required by your state worker compensation laws.
- To share information related to specialized government functions, such as military and veteran activities, national security and intelligence activities and protective services for the President and others.

4. USES AND DISCLOSURES REQUIRING WRITTEN AUTHORIZATION

For any other activity or purpose not listed above or as otherwise permitted by law we must obtain your written authorization prior to using or sharing your health information. If you provide a written authorization and you change your mind, you may revoke your authorization in writing at any time. Once an authorization has been revoked, we will no longer use or disclose the health information as outlined in the authorization form; however, you should be aware that we may not be able to retract a use or disclosure that was previously made based on a valid authorization.

5. YOUR HEALTH INFORMATION RIGHTS

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

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

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

6. STATE LAW

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

7. CHANGES TO THIS NOTICE

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

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

8. COMPLAINTS

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

9. CONTACT INFORMATION

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

at: CalPERS c/o CVS Caremark – Attn: Privacy Officer
MC 016, PO BOX 52072
Phoenix, AZ 85072-2072

Section 1.5	We must give you information about the plan, its network of pharmacies, and your covered drugs
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As a member of PERSCare Medicare Part D PDP, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in Spanish, Braille, in large print or audio formats.)

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

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

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

- If 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 7 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you are not happy or if you disagree with a decision we make about what drug is covered for you under CalPERS supplemental coverage, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see page 125 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision.
- If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.6	We must support your right to make decisions about your care
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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 can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?

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

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

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

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

Section 1.8	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

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

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

Section 1.9	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Customer Care** (phone numbers are printed on the last page of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

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

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

- For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost) Chapter 4 tells what you must pay for your Part D prescription drugs.
- If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for more information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of our plan.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Customer Care (phone numbers are printed on the last page of this booklet).*
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - **When moving, you should always contact CalPERS and update your address.**
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- ***Call Customer Care for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
 - Phone numbers and calling hours for Customer Care are printed on the last page of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

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

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BACKGROUND

SECTION 1 Introduction

Section 1.1	What to do if you have a problem or concern
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The following section details your appeals rights for drugs covered by Medicare. Your appeals rights for drugs not covered by Medicare begins on page 125. CVS/Caremark will help you navigate the appropriate appeals process. If you have any questions contact CVS/Caremark at 855-479-3660 (for TTY 1-866-236-1063).

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

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

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

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

Section 1.2	What about the legal terms?
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There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

My problem is about benefits or coverage.

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

No.

My problem is not about benefits or coverage.

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

COVERAGE DECISIONS AND APPEALS

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

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

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for Part D prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered. The coverage request rules and appeals process for drugs covered through your CalPERS supplemental coverage can be found beginning on page 125 or you can contact Customer Care for any questions regarding your supplemental benefit.

Asking for coverage decisions

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

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

Making an appeal

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

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

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

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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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 Customer Care** (phone numbers are printed on the last page).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other prescriber can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 or a Level 2 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Care (phone numbers are printed on the last page of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at www.caremark.com/calpers) The form gives that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

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

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



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

Section 5.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug
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Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Please refer to our plan’s *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

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

Part D coverage decisions and appeals

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

Legal Terms	An initial coverage decision about your Part D drugs is called a “coverage determination.”
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Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:

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

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

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

Which of these situations are you in?			
<p>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with Section 5.2 of this chapter.</p>	<p>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?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to Section 5.4 of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to Section 5.4 of this chapter.</p>	<p>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?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to Section 5.5 of this chapter.</p>

Section 5.2 What is an exception?

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

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

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

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “ formulary exception. ”
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- You can ask us to provide a higher level of coverage for your drug. If applicable, and your drug is contained in our Non-Preferred Brand tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand tier instead. This would lower the amount you must pay for your drug. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

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

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “ formulary exception. ”
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- The extra rules and restrictions on coverage for certain drugs include:
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *For plans with Step Therapy, being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *For plans with Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

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

**Legal
Terms**

Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a “**tiering exception.**”

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

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

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

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

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

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us 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 us to pay you back for a drug**, start by reading Chapter 5 of this booklet: *Asking us to pay our share of the costs for covered drugs*. Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

If your health requires it, ask us to give you a “fast coverage decision”

Legal Terms	A “fast coverage decision” is called an “ expedited coverage determination. ”
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- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

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

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.

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

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

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

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

Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”
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Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start your appeal, you, your representative, your doctor, or other prescriber must contact us.**
 - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs*.
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1.
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (*How to contact our plan when you are making an appeal about your part D prescription drugs*).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms	A “fast appeal” is also called an “ expedited redetermination. ”
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- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 5.4 of this chapter.

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

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

Deadlines for a “fast” appeal

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

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 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 we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6	Step-by-step: How to make a Level 2 Appeal
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If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1: To make a Level 2 Appeal, you, your representative, your doctor, or other prescriber must contact the Independent Review Organization and ask for a review of your case.

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

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

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

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

Deadlines for “standard” appeal at Level 2

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

- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

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 the dollar value that must be in dispute to continue with the appeals process.

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

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

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

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

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

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

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

Level 4 Appeal The Appeals Council will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process for Part D drugs.

You have specific coverage request rules and appeal rights for drugs covered by your CalPERS supplemental coverage. These rules and rights can be found beginning on page 125.

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”

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 Customer Care 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 Customer Care or other staff at the plan?
 - 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?

The next page has more examples of possible reasons for making a complaint

Possible complaints

(continued)

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”
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**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
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Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care will let you know. Call 1-855-479-3660, 24 hours a day. 7 days a week. TTY users should call 1-866-236-1063.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

You may submit a grievance to us in writing to:

Medicare Prescription Drug Plans
Grievance Department
445 Great Circle Rd
Nashville, TN 37228

- Upon receipt of your complaint, we will initiate the Grievance process.
 - If you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing.
 - We must notify you of our decision about your complaint (grievance) as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

- In certain cases, you have the right to ask for a fast review of your complaint. This is called the Expedited Grievance Process. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations.
 - We deny your request for a fast review of a request for drug benefits.
 - We deny your request for a fast review of an appeal of denied drug benefits.
 - You may submit this type of complaint by phone by calling Customer Care at the number on the last page of this booklet
- For a fast complaint about a denial regarding your request for expedited coverage determinations or redeterminations, you may submit the complaint by calling Customer Care. We will contact you within 24 hours by phone to notify you of our response. This will also be followed up by a written response.
- **Whether you call or write, you should contact Customer Care right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a “fast complaint” is also called an “expedited grievance.”
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Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don’t 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
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You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5	You can also tell Medicare about your complaint
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You can submit a complaint about PERSCare Medicare Part D PDP directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 8. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1	This chapter focuses on ending your membership in our plan
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Ending your membership in PERSCare Medicare Part D PDP may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1	Usually, you can end your membership during the Annual Enrollment Period
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You can end your membership during the **Annual Enrollment Period** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from September 16, 2013 to October 11, 2013. Please contact CalPERS for more information about your Annual Enrollment Period.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare prescription drug plan. If you choose to enroll in another Medicare Prescription Drug Plan that is not part of a CalPERS health plan, then you may not maintain enrollment in PERSCare.
- 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 PERSCare.
- A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
 - If you enroll in a non-CalPERS Medicare health plan, you will be disenrolled from PERSCare. If you do not want to keep PERSCare, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.)

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1, 2014.

Section 2.2	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of PERSCare Medicare Part D PDP may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - If you have moved out of your plan’s service area.
 - If you have Medicaid.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Care (phone numbers are printed on the last page of this booklet).

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare prescription drug plan. CalPERS members may only choose another CalPERS plan with Part D coverage. If they choose to enroll in a Part D plan that is not part of a CalPERS health plan, then they may not maintain enrollment in the CalPERS health plan.
 - Original Medicare *without* a separate Medicare prescription drug plan.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
 - – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
 - If you enroll in most Medicare health plans, you will automatically be disenrolled from PERSCare Medicare Part D PDP when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep PERSCare Medicare Part D PDP for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

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

Section 2.3	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Care** (phone numbers are printed on the last page of this booklet).
- You can find the information in the *Medicare & You 2014* 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 (<http://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?
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Section 3.1	Usually, you end your membership by enrolling in another plan
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, there are two situations in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep PERSCare Medicare Part D PDP for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or ask to be disenrolled from our plan.
- **This prescription coverage is offered in conjunction with your medical coverage. If you choose a Medicare prescription drug plan other than PERSCare Medicare Part D PDP, you will need to seek medical coverage at your own expense.**

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Care if you need more information on how to do this (phone numbers are printed on the last page of this booklet)
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 4, Section 9 for more information about the late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• Another Medicare prescription drug plan.	<ul style="list-style-type: none">• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from PERSCare Medicare Part D PDP when your new plan’s coverage begins and you will lose your health coverage provided by CalPERS.
<ul style="list-style-type: none">• A Medicare health plan.	<ul style="list-style-type: none">• Enroll in the Medicare health plan. You will automatically be disenrolled from PERSCare when your new plan’s coverage begins and you will lose your health coverage provided by CalPERS. If you want to leave our plan, you must <i>either</i> enroll in another Medicare prescription drug plan <i>or</i> ask to be disenrolled.

**If you would like to switch
from our plan to:**

This is what you should do:

To ask to be disenrolled, you must send us a written request. Contact Customer Care (phone numbers are printed on the last page of this booklet) if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).

- Original Medicare *without* a separate Medicare prescription drug plan.
 - **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 Customer Care if you need more information on how to do this (phone numbers are printed on the last page 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
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If you leave PERSCare Medicare Part D PDP, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

- If you use an out of network pharmacy, we will reimburse you our network contracted rate minus your cost share amount for the drug. You must submit a paper claim in order to be reimbursed.

SECTION 5 PERSCare Medicare Part D PDP must end your membership in the plan in certain situations

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

PERSCare must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you enroll in another Medicare Part D Plan.
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
 - If you move or take a long trip, you need to call Customer Care to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Care are printed on the last page of this booklet.)
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.) If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are not receiving extra help and you or CalPERS, do not pay the plan premiums by the due date.
 - We must notify you, or your employer group/union, in writing that you have 60 days from the due date to pay the plan premium before we end your membership.
- 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?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Care** for more information (phone numbers are printed on the cover of this booklet).

Section 5.2	We cannot ask you to leave our plan for any reason related to your health
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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
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

Chapter 9. Legal notices

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SECTION 3	Notice about Medicare Secondary Payer subrogation rights	124
SECTION 4	Other important legal notices	124

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 nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, PERSCare Medicare Part D PDP, as a Medicare prescription drug plan, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Other important legal notices

Drug names listed in this and any other Plan documents are the registered and/or unregistered trademarks of third-party pharmaceutical companies unrelated to and unaffiliated with the plan sponsor CVS Caremark or its subsidiaries or affiliates. We include these trademarks here for informational purposes only and do not imply or suggest affiliation between the plan sponsor and such third-party pharmaceutical companies.

PRESCRIPTION DRUG CLAIM REVIEW AND APPEALS PROCESS FOR CalPERS SUPPLEMENTAL COVERAGE

CVS Caremark manages both the administrative and clinical prescription drug appeals process for CalPERS supplemental coverage under the PERSCare Medicare Part D PDP. The supplemental coverage may cover prescription drugs not covered by Medicare under Part D. If a Member wishes to request a coverage determination for supplemental coverage, the Member or the Member's Authorized Representative (Member) may contact CVS Caremark's Customer Care at 1-855-479-3660 (1-866-236-1069 TDD). Customer Care will provide the Member with instructions and the necessary forms to begin the process. The request for a coverage determination must be made in writing to CVS Caremark. The written response the Member will receive back is an initial determination. When the Member receives this information, it will tell them how to appeal the initial determination in writing to CVS Caremark if they are not satisfied with the response. A denial of the request is an adverse benefit determination, and may be appealed through an Internal Review process described below. If the appeal is denied through the Internal Review process, it becomes a final adverse benefit determination and the Member may pursue an independent External Review or Administrative Review directly with CalPERS. The detailed information for the process is described below.

1. Denial of claims of benefits

Any denial of a claim is considered an adverse benefit determination (ABD) and is eligible for Internal Review as described in section 2 below. Final Adverse Benefit Determinations (FABD) resulting from the Internal Review process may be eligible for External Review in cases involving Medical Judgment, as described in section 3 below.

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

The Member may request an Internal Review for each medication denied through Coverage Management Programs within one-hundred eighty (180) days from the date of the notice of initial benefit denial sent by CVS Caremark. This review is subject to the Internal Review process as described in section 2 below. Requests for review should be directed to:

CVS Caremark
P. O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-689-3092

If the Member is dissatisfied with the determination made by CVS Caremark in the Internal Review process, the Member may request an independent External Review as described in section 3 below or CalPERS Administrative Review as described in section 4 below.

PRESCRIPTION DRUG REVIEW AND APPEALS PROCESS FOR CaIPERS SUPPLEMENTAL COVERAGE

b. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for prescription drugs are not payable when first submitted to CVS Caremark. If CVS Caremark determines that a claim is not payable in accordance with the terms of the Plan, CVS Caremark will notify the Member 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, the Member may be asked to resubmit the claim with complete information to CVS Caremark. If after resubmission the claim is determined to be payable in whole or in part, CVS Caremark will take necessary action to pay the claim according to established procedures. If the claim is still determined to be not payable in whole or in part after resubmission, CVS Caremark will inform the Plan Member in writing of the reason(s) for denial of the claim.

If the Member is dissatisfied with the denial made by CVS Caremark, the Member may request an Internal Review as described in section 2 below.

2. Internal Review

The Member may request a review of an ABD by writing to CVS Caremark within one hundred eighty (180) days of receipt of the ABD. Requests for Internal Review should be directed to:

CVS Caremark
P. O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-689-3092

Reviews of an ABD involving a medication to treat a condition that could seriously jeopardize the Member's life, health or ability to regain maximum function; or, in the opinion of the Member's physician, would subject the Member to severe pain that cannot be adequately managed without the medication, should be submitted as soon as possible from the date of the ABD and be clearly identified as Urgent. (See definition of "Expedited Process" on page 104)

The Member 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. The cost of copying and mailing medical records required for CVS Caremark to review its determination is the responsibility of the person or entity requesting the review.

The Member 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.

PRESCRIPTION DRUG REVIEW AND APPEALS PROCESS FOR CalPERS SUPPLEMENTAL COVERAGE

CVS Caremark will acknowledge receipt of a request for Internal Review by written notice to the Member within five (5) business days.

For prior authorization of prescription services (Pre-Service Appeal or Concurrent Appeal), CVS Caremark will provide a determination within 30 days of the initial request for Internal Review and includes the following steps:

- 15 days for a determination regarding claim or benefit; and
- an additional 15 days for a determination regarding Medical Judgment.

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

For a review of an ABD subject to the Expedited Process, a determination will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours from the time of the request. If the Member's situation is subject to the Expedited Process, they can simultaneously request an independent External Review described in section 3 below.

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

Upon receipt of an FABD the Member may pursue the External Review process described in sections 3 below or the CalPERS Administrative Review process as described in section 4 below.

3. 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, the Member will be notified that they may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to the Member. The Member must request an independent External Review, in writing, no later than four (4) months from the date of the FABD. The prescription in dispute must be a covered benefit. If the Member requests a CalPERS Administrative Review before requesting an independent External Review, the Member will be provided an additional four (4) months to request an independent External Review in the event CalPERS Administrative Review determination upholds CVS Caremark's denial of benefits.

PRESCRIPTION DRUG REVIEW AND APPEALS PROCESS FOR CalPERS SUPPLEMENTAL COVERAGE

The Member may also request an independent External Review if CVS Caremark fails to render a decision within the timelines specified above for Internal Review or if they think the Internal Review process is not full and fair. Examples of not being full and fair include failure to follow the procedures or not utilizing proper professional experts in determination of the Member's denial. Please note, the process will be deemed full and fair if such errors are minor, not detrimental to the Member's appeal, or attributable to good cause or matters beyond CVS Caremark's control. For a more complete description of these rights, please see 45 Code of Federal Regulations section 147.136.

4. Request for CalPERS Administrative Review

If the Member is not satisfied with CVS Caremark's FABD, the independent External Review decision, or the Member does not want to pursue the independent External Review process, the Member may request a CalPERS Administrative Review. See the section entitled "CalPERS Administrative Review and Administrative Hearing" on the next page.

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

1. Administrative Review

If the Member or the Member's Authorized Representative (Member) remains dissatisfied after exhausting the Internal Review procedures outlined in pages 130 the Member may submit a request for CalPERS Administrative Review. This request must be submitted in writing to CalPERS within thirty (30) days from the date of the Final Adverse Benefit Determination (FABD) or, if applicable, the independent External Review decision in cases involving Medical Judgment.

The request must be mailed to:

CalPERS Health Plan Administration Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

The Member(s) are encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for Administrative Review, which gives permission to the Plan to provide medical documentation to CalPERS. The ARHI form will be provided to the Member with the FABD letter from CVS Caremark. If a member would like to designate an Authorized Representative to represent him or her in the Administrative Review process, Section IV. Election of Authorized Representative of the ARHI form must be completed and signed by the Member. An ARHI assists CalPERS in obtaining health information needed to make a decision regarding a Member's request for Administrative Review. If the Member has additional medical records from Providers that the Member believes are relevant to CalPERS review, those records should be included with the written request. The Member should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. The person or entity requesting review is 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 will attempt to provide a written determination within thirty (30) 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 72 hours from the time of the request.

Please note that if the Member requests an independent External Review before, at the same time, or after the Member makes a request for CalPERS Administrative Review, but before a determination has been made, CalPERS will not issue its determination until the independent External Review decision is issued.

CalPERS cannot review claims of medical malpractice, i.e. quality of care.

If the Member requested a CalPERS Administrative Review before requesting an independent External Review, and the CalPERS Administrative Review determination upholds the FABD, the Member will be provided an additional four (4) months from the

date of the determination to request an independent External Review. See section 3, *Prescription Drug Review and Appeals Process For CalPERS Supplemental Coverage* on page 108 for independent External Review procedures.

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

2. Administrative Hearing

The Member 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.

The Member must file for Administrative Hearing within thirty (30) days of the date of the Administrative Review determination, or within thirty (30) days of the independent External Review decision if the Member elected the External Review process after an Administrative Review determination. See section 1 above. Upon satisfactory showing of good cause, CalPERS may grant additional time to file an appeal, not to exceed thirty (30) days.

The request for an Administrative Hearing must set forth the facts and the law upon which the appeal is based. The request should include any additional arguments and evidence favorable for Member's 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). The Member 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 the Member within two weeks of the Board's open meeting.

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

3. Appeal Beyond Administrative Review and Administrative Hearing

If the Member is still dissatisfied with the Board's decision, the Member may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

A Member 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.** The Member may, at his or her 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, the Member may be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney even if the Member prevails on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, the Member may present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense. Neither CalPERS nor the administrator will reimburse the Member for the costs of experts, consultants or evaluations.

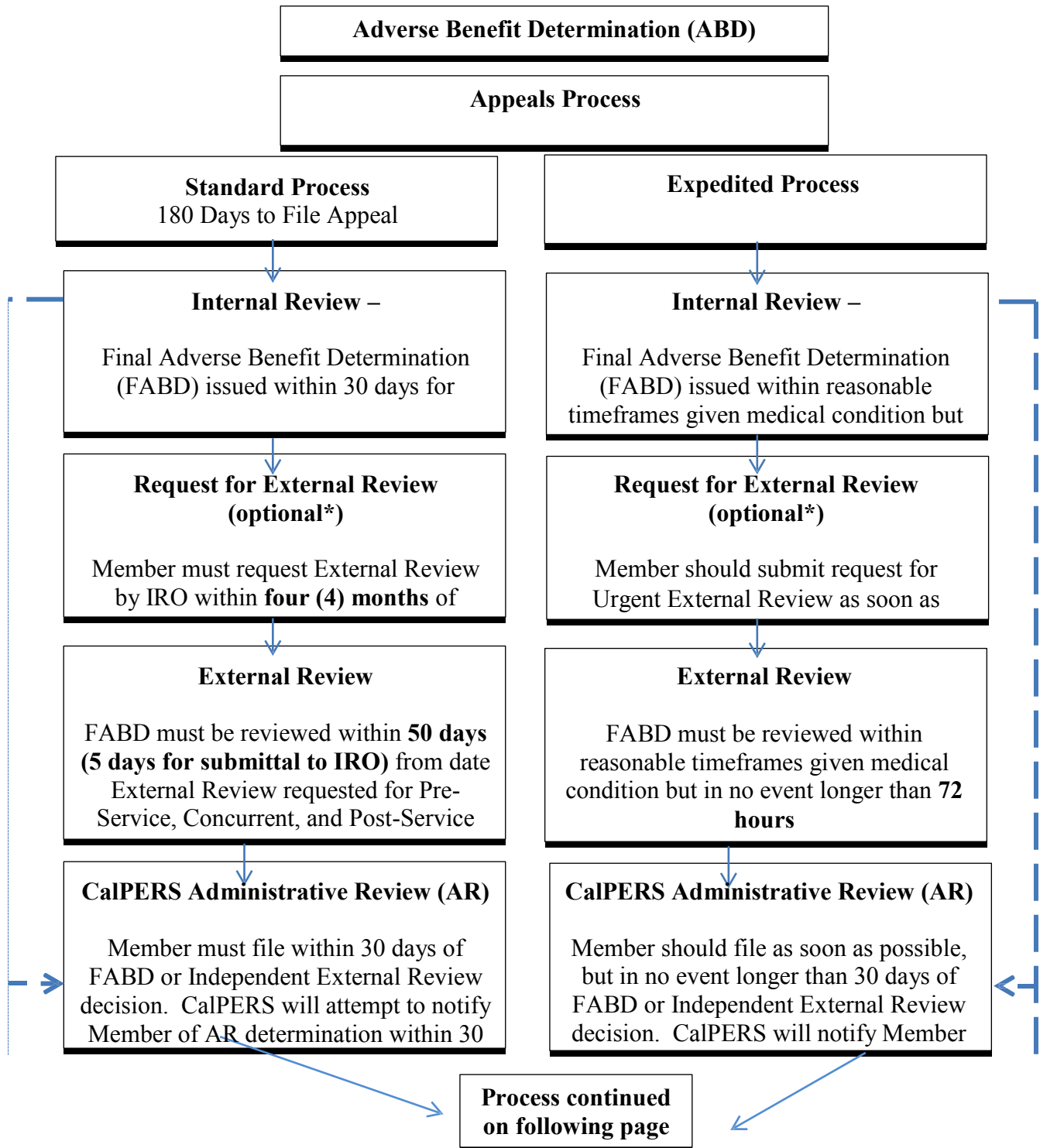
Service of Legal Process

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

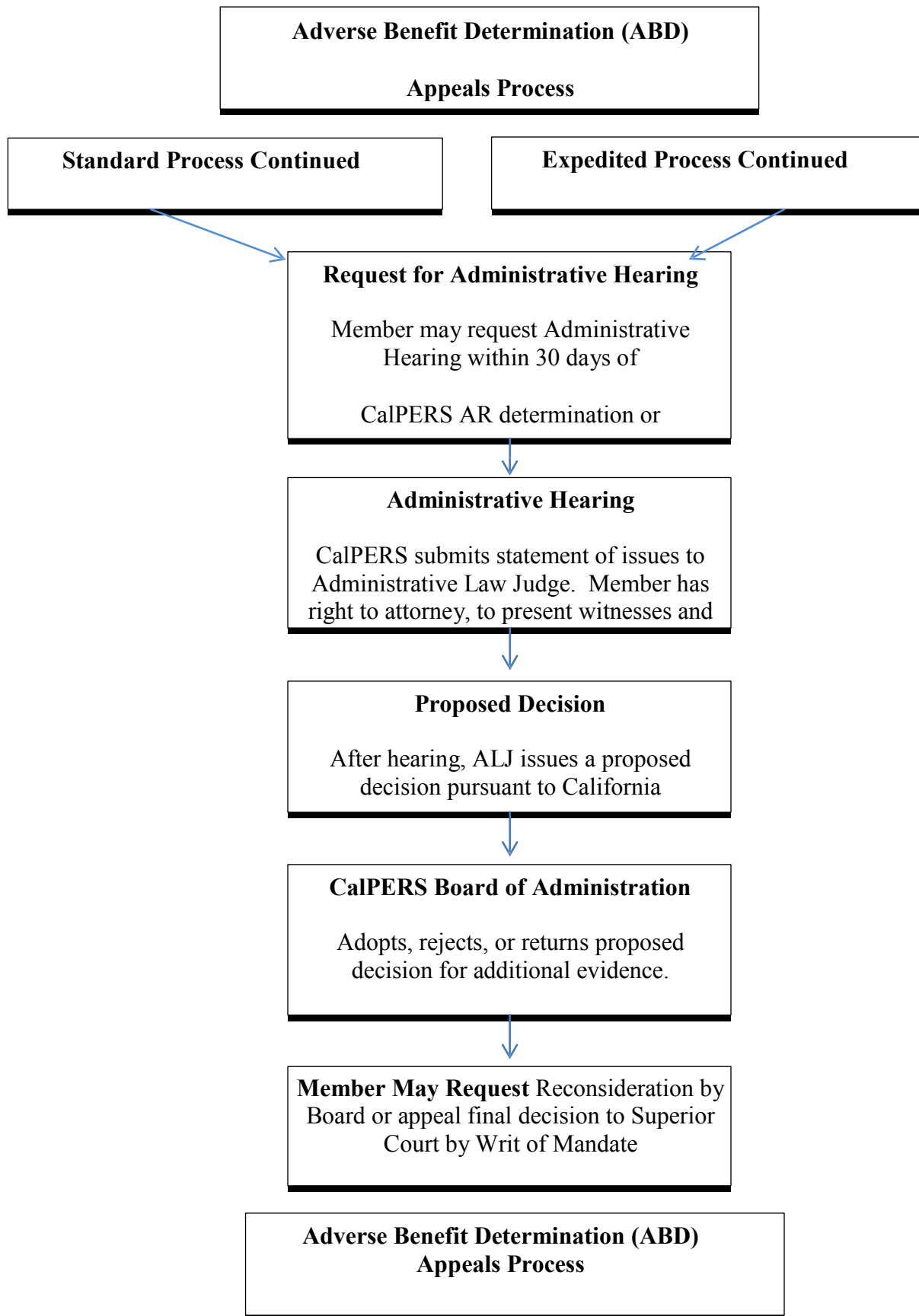
CaIPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

ADVERSE BENEFIT DETERMINATION (ABD) CHART



*For FABDs that involve "Medical Judgment," the Member may request an External Review or proceed directly to CalPERS for AR, under either the Standard or Expedited Process.

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING



CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

The flow chart above and definitions below are included to assist the Member with understanding his or her rights and the provisions of this Plan related to Internal Claims and Appeals, and the independent External Review process available in the event a denial is based on Medical Judgment. The information provided here is general and simplified, consistent with accuracy, but is not intended to be the definitive statement of state or federal law.

Administrative Hearing (AH)– A legal hearing conducted by the Office of Administrative Hearings and governed by the rules established in the California Administrative Procedure Act, (Government Code section 11370). Members may avail themselves of their administrative rights by appealing a FABD or independent External Review decision to CalPERS for Administrative Review. If CalPERS upholds the FABD or independent External Review decision, CalPERS will notify the Member that he or she may formally appeal that decision and request an Administrative Hearing.

Administrative Review (AR) – A review conducted by CalPERS after CVS Caremark’s Internal Review process and either before or after the Member elects to participate in the independent External Review process. A Member who wishes to appeal an independent External Review decision must submit his or her appeal to CalPERS for Administrative Review to proceed to Administrative Hearing and exhaust his or her administrative rights under California law.

Adverse Benefit Determination (ABD) – Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment based on a determination of a Member’s eligibility to participate in a plan, and any denial, reduction or termination of, or failure to provide or make payment for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Authorized Representative – A person or entity a Member designates to act on his or her behalf regarding his or her AR or AH.

Concurrent Appeal – An appeal of a claim for approval of medical care, treatment or medication during the time such care, treatment or medication is being rendered.

Expedited Process – The process to review a claim for medical care, treatment or medication with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or, in the opinion of a physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Decisions regarding these claims must be made as soon as possible consistent with the medical exigencies involved, but in no event longer than 72 hours.

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

External Review – A Member who receives a Final Adverse Benefit Determination (FABD) is eligible to submit the FABD to an independent External Review if the plan's decision involved making a medical judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of health care service or treatment requested. The Member will receive notice of his or her right to request an independent External Review at the time the Plan issues the FABD. The independent External Review is conducted by an Independent Review Organization (IRO), as defined below; the IRO's independent External Review decision is binding on the Health Plan. An independent External Review decision that upholds the FABD, or denial of benefit, may be submitted to CalPERS for Administrative Review. The independent External Review process is optional and must be elected by the Member within four (4) months of the FABD (defined below).

Final Adverse Benefit Determination (FABD) – An ABD that has been upheld by a plan or issuer at the completion of the Internal Review process.

Independent Review Organization (IRO) – An entity that is accredited by a nationally recognized private accrediting organization that conducts Independent External Reviews of FABDs.

Internal Review – The review conducted by CVS Caremark for an ABD.

Medical Judgment – An ABD or FABD that is based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or its determination that a treatment is experimental or investigational, or a rescission of coverage (retroactive cancellation of coverage due to a reduction in time base).

Pre-Service Appeal – An appeal of a claim for approval of medical care, treatment or medication prior to the time such care, treatment or medication is rendered.

Post-Service Appeal – An appeal of a claim for approval of medical care, treatment or medication after the time such care, treatment or medication has been rendered.

Chapter 10. Definitions of important words

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period for CalPERS is from September 16, 2013 until October, 11 2013.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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 \$4550 in covered drugs during the covered year.

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

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

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a prescription drug.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following two types of payments: (1) any fixed "copayment" amount that a plan requires when a specific drug is received; or (2) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily cost sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay.

Cost-Sharing Tier – If applicable for your plan, every drug on the list of covered drugs is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Care.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply. Here is an example*: If your copay for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is \$1 per day. This means you pay \$1 for each day's supply when you fill your prescription.

- *Dollar amounts used in this example are for illustrative purposes only and do not reflect your actual copayments.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total Part D drug expenses have reached \$2850, including amounts you’ve paid and what our plan has paid on your behalf.

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’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without “creditable” prescription drug coverage.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See “Extra Help.”

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. In California, this program is called Medi-Cal. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare a Medicare Cost Plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted. This Coverage Gap Discount Program does not apply to the PERSCare Medicare Part D PDP.

Medicare-Covered Services – Services covered by Medicare Part A and Part B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

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

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 doesn’t 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. This amount can vary by employer group/union.

- **True out-of-pocket Costs (TrOOP)** - The expenses that count toward a person's Medicare drug plan out-of-pocket threshold (for example \$4550 in 2014). This includes amounts paid by you or qualified payers on your behalf towards the cost of your covered drugs. Generally payments by family and friends and charities count towards TrOOP, but not payments by other health plans. TrOOP costs determine when a person's catastrophic coverage portion of their Medicare Part D prescription drug plan will begin. In other words, TrOOP defines when you exit the Doughnut Hole or Coverage Gap and enter into the Catastrophic Coverage stage of your Medicare Part D prescription drug plan.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Care (phone numbers are printed on the last page of this booklet).

Part C – see “**Medicare Advantage (MA) Plan.**”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (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.

Plan – Means PERSCare Medicare Part D Prescription Drug Plan.

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

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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 Social Security 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.

Customer Care

CALL	1-855-479-3660 Calls to this number are free. 24 hours a day. 7 days a week. Customer Care also has free language interpreter services available
TTY	866-236-1069 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
WRITE	445 Great Circle Road Nashville, TN 37228
WEBSITE	http://www.caremark.com/calpers

Health Plan Administration Division
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