

# California's Valued Trust Prescription Benefits

October 1, 2021



California's  
Valued Trust

Healthcare Benefits for the Education Community

Dear Plan Member:

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

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

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

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

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

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## **PRESCRIPTION DRUG COVERAGE**

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

CVT provides a medical and pharmacy benefit plan combination identification (ID) Card for each subscriber and their eligible dependents enrolled in a CVT PPO (Preferred Provider Organization) or EPO (Exclusive Provider Organization) Plan. All cards received will be in the subscriber's name only.

## **PRESCRIPTION ACCESS**

### **RETAIL PHARMACY NETWORK**

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

*For new prescriptions:*

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

*For refills:*

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

### **RETAIL PHARMACY**

To maximize the value of your prescription drug benefit, your prescription should be filled at a CVS Caremark network pharmacy (for example: CVS, Walgreens, Vons, etc.). The CVS Caremark network consists of roughly 65,000 participating pharmacies. Using a network pharmacy is generally more convenient and less expensive. Network pharmacies can easily access information about your prescription benefit program and your applicable copay. You will not need to file any paperwork when you use a CVS Caremark network pharmacy. Should you choose to have your prescription filled at an out of network pharmacy you will be required to pay 100 percent of prescription cost at the pharmacy. Then you will need to submit a paper claim form along with the original receipt(s) to CVS Caremark for reimbursement of covered expenses. If you fill prescriptions at a non-participating pharmacy you may be able to save by having your prescription transferred to a participating retail pharmacy. To do this, contact a CVS Caremark participating retail pharmacy, and tell the pharmacist where your prescription is currently on file. If possible, have your prescription bottle with you when you make the call so you can answer any

questions. The pharmacist will contact the non-participating pharmacy and make the transfer for you. When you pick up the prescription, bring along your CVS Caremark ID card so that the pharmacist can verify coverage.

## **MAIL ORDER**

*For new prescriptions:*

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

*For refills:*

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

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

## **MAINTENANCE CHOICE PROGRAM**

CVT offers two options for individuals who are on maintenance or long-term medications or who will be on the same medication for a long period of time. Maintenance or long-term medications are most commonly used to treat a chronic illness or long term condition, such as asthma, diabetes, high blood pressure, arthritis or cardiovascular disease. Members and their families must choose to receive a 90-day supply of their maintenance

medication either by mail through CVS Caremark Mail Service Pharmacy or to pick them up at a CVS/pharmacy near them. This service also follows the same generic vs. brand drug rules as noted in the 'Mandatory Generics' section of this document. The copay remains the same for both services. Mail order prescriptions may be filled with up to a 90-day supply including free standard shipping to your home.

## **PRESCRIPTION PLAN COPAYS**

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

*You may also be responsible for:*

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

The following CVT prescription plan options are available to pair with Anthem Blue Cross PPO or HMO plans, Blue Shield of California PPO or HMO plans, Aetna PPO plans and Sutter Health | Aetna EPO plans.

	<b>Plan A</b>	<b>Plan B*</b>	<b>Plan C*</b>	<b>Plan D*</b>	<b>ValuRx Plan**</b>
<b>Retail</b> (up to 30-day supply)	\$5 Generic \$22 Brand	\$7 Generic \$15 Preferred Brand \$30 Non-Preferred Brand	\$7 Generic \$25 Preferred Brand \$40 Non-Preferred Brand	\$150 Brand Deductible *** \$10 Generic \$40 Preferred Brand \$100 Non- Preferred Brand	\$150 Brand Deductible *** \$0 Generic \$30 Brand
<b>Mail-Order / Maintenance Choice @ a CVS/pharmacy</b> (up to a 90- day supply)	\$10 Generic \$44 Brand	\$15 Generic \$35 Preferred Brand \$70 Non-Preferred Brand	\$15 Generic \$60 Preferred Brand \$90 Non-Preferred Brand	\$150 Brand Deductible \$25 Generic \$100 Preferred Brand \$250 Non- Preferred Brand	\$150 Brand Deductible \$0 Generic \$60 Brand

Plan pays 100% of the medication cost once the deductible and out of pocket maximum requirements have been met. Both medical and pharmacy expenses apply to the out of pocket maximum. Refer to the medical plan for the appropriate out of pocket maximum amount.

See page 12 for PrudentRx Copay Program for Specialty Medications

\*Medications in a 3-tier benefit structure are divided into 3 groups or copayment/coinsurance levels. Generic drugs are in the 1<sup>st</sup> tier copayment; certain brand-name drugs, including preferred brands, are in the 2<sup>nd</sup> tier copayment; and non-preferred brands are in the 3<sup>rd</sup> tier copayment. In most cases there are generic and/or preferred brand alternatives available for non-preferred brands. You should discuss the possibility of being prescribed a preferred brand or generic with your physician, if appropriate.

\*\* See page 14 for specific ValuRx plan details; For members enrolled in CVT's Medicare Part D SilverScript coverage review your Evidence of Coverage document for ValuRx copay information.

\*\*\* 4<sup>th</sup> Quarter Carry Over: Any deductible incurred from October 1 through December 31 and applied to your Calendar Year Brand Deductible for that year will also be applied toward your Calendar Year Brand Deductible for the next year. For members enrolled in CVT's Medicare Part D SilverScript coverage: The 4<sup>th</sup> Quarter Carry Over is not applicable. The Deductible applies to Formulary Brand and all Non-Formulary, including generic, medications.

The following PPO plans are available through Anthem Blue Cross, Blue Shield of California or Aetna network of medical providers and CVS Caremark prescription benefits.

Bronze PPO Plan *	HDHP 1 Plan	HDHP 2 Plan	HDHP 3 Plan
<p><b>Deductible:</b> Individual: \$5,000 Family: \$10,000</p> <p><b>Out of Pocket Max:</b> Individual: \$6,350 Family: \$12,700</p>	<p><b>Deductible:</b> Individual: \$1,350 Family: \$2,700 (no individual limit applies)</p> <p><b>Out Of Pocket Max:</b> Individual: \$4,250 Family: \$8,500</p> <p>Family = Employee with one or more covered dependents. No one individual will pay more than \$7,150</p>	<p><b>Deductible:</b> Individual: \$2,000 Family: \$4,000 (no individual limit applies)</p> <p><b>Out-of-Pocket Max:</b> Individual: \$5,250 Family: \$10,500</p> <p>Family = Employee with one or more covered dependents. No one individual will pay more than \$7,150</p>	<p><b>Deductible:</b> Individual: \$1,500 Family: \$3,000 (no individual limit applies)</p> <p><b>Out-of-Pocket Max:</b> Individual: \$6,250 Family: \$12,500</p> <p>Family = Employee with one or more covered dependents. No one individual will pay more than \$7,150</p>
<p><b>Retail:</b> Subject to deductible then: \$25 Generic Copay \$50 Brand Copay</p>	<p><b>Retail:</b> Paid at 90% After deductible is met</p>	<p><b>Retail:</b> Paid at 80% After deductible is met</p>	<p><b>Retail:</b> Paid at 60% After deductible is met</p>
<p><b>Mail Order:</b> Subject to deductible then: \$50 Generic Copay \$100 Brand Copay</p>	<p><b>Mail Order:</b> Paid at 90% After deductible is met</p>	<p><b>Mail Order:</b> Paid at 80% After deductible is met</p>	<p><b>Mail Order:</b> Paid at 60% After deductible is met</p>

\* See page 12 for PrudentRx Copay Program for Specialty Medications

\* 4<sup>th</sup> Quarter Carry Over: Any deductible incurred from October 1 through December 31 and applied to your Calendar Year Deductible for that year will also be applied toward your Calendar Year Deductible for the next year.

The following EPO plans are available through Sutter Health | Aetna network of medical providers and CVS Caremark prescription benefits.

<b>EPO 70 BZ *</b>	<b>EPO HSA</b>
<p><b>Deductible:</b> Individual: \$5,000 Family: \$10,000</p> <p><b>Out of Pocket Max:</b> Individual: \$6,350 Family: \$12,700</p>	<p><b>Deductible:</b> Individual: \$1,350 Family: \$2,700 (no individual limit applies)</p> <p><b>Out-of-Pocket Max:</b> Individual: \$4,250 Family: \$8,500</p> <p>Family = Employee with one or more covered dependents. No one individual will pay more than \$6,850</p>
<p><b>Retail:</b> Subject to deductible then: \$25 Generic Copay \$50 Brand Copay</p>	<p><b>Retail:</b> Paid at 80% After deductible is met</p>
<p><b>Mail Order:</b> Subject to deductible then: \$50 Generic Copay \$100 Brand Copay</p>	<p><b>Mail Order:</b> Paid at 80% After deductible is met</p>

\* See page 12 for PrudentRx Copay Program for Specialty Medications

\* 4<sup>th</sup> Quarter Carry Over: Any deductible incurred from October 1 through December 31 and applied to your Calendar Year Deductible for that year will also be applied toward your Calendar Year Deductible for the next year.

## **DRUG COVERAGE OVERVIEW**

### **PRIOR AUTHORIZATION**

In order for some prescription medications to be covered as a part of your benefit, a Prior Authorization (PA) evaluation will be conducted to determine if the medications' prescribed use meets defined clinical criteria. Through this process, your doctor and CV/caremark pharmacists will work together to ensure that the drug you are prescribed is the most appropriate for your condition.

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

Please have your physician call **Caremark Customer Care** at **1-800-294-5979** to start the PA review process. You can call **Customer Care** at **1-888-354-6390** if you have questions regarding your PA or visit **www.caremark.com** for details surrounding your specific drug scenario.

## **SAVING WITH GENERICS**

### **What is a Brand Name Drug?**

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

When the patent expires, other pharmaceutical companies can apply to the FDA for approval to market a generic version of the branded medication.

### **What is a Generic Medication?**

A generic medication is a Food and Drug Administration (FDA) approved version of a brand name drug. The FDA reviews each generic medication to ensure that it is comparable to the brand name drug in safety, effectiveness, quality, and performance (how it works in the body). The generic version is used to treat the same diseases (blood pressure, cholesterol, diabetes, etc.) usually in the same form (tablet, liquid, cream, etc.) as its brand name counterpart.

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

#### *Your first choice: Ask for generics*

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

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

#### *Your second choice: Request medications from your CVS Caremark Drug List:*

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

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

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

### **Mandatory Generic**

Prescriptions will be dispensed with a generic equivalent, if available. If your doctor indicates “Dispense as Written” (DAW) on the prescription you cannot choose a generic without a new prescription. The out-of-pocket amount you will be required to pay will increase if you or your doctor requests a brand when there is a generic equivalent

available - you will be responsible for paying the brand copay plus the cost difference between the generic and brand-name drug.

**Dispense as Written EXAMPLE:** *If you fill a brand name drug when a generic is available, you will be charged a Dispense As Written (DAW) penalty. For example, the doctor writes a prescription for Keppra. If the doctor or member requests the brand instead of generic, the copay amount charged will be the applicable brand copayment PLUS the cost difference between the brand drug and the generic drug. In comparison, dispensing the generic version Levetiracetam will only charge the generic copay.*

*When using CVT's Pharmacy Plan D that has a \$150 brand only deductible, the brand copay will apply to the deductible and out of pocket. The penalty will not apply toward meeting the brand only deductible or out of pocket. For specific test claims please call the customer service number on the back of your ID card.*

### **GENERIC STEP THERAPY**

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

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

## **PHARMACY PROGRAMS**

### **SPECIALTY PHARMACY SERVICES**

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

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

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

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

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

Please note that the list of Specialty medications is subject to change. To learn more about Specialty Pharmacy Services please visit the CVS Caremark website or call **CVS Caremark Connect at 1-800-237-2767**.

### **PRUDENTRX COPAY PROGRAM FOR SPECIALTY MEDICATIONS**

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, CVT has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications for CVT pharmacy plans A, B, C, D, V, PPO Bronze and EPO 70BZ. The PrudentRx Copay Program is not applicable for members enrolled in CVT's Medicare Part D SilverScript coverage. The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled members who get a copay card for their specialty medication (if applicable), will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that

are not considered to be “essential health benefits” is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

**PrudentRx** can be reached at **1-800-578-4403** to address any questions regarding the PrudentRx Copay Program.

### **PERFORMANCE DRUG LIST (PDL)**

The PDL is a list of commonly prescribed medications in select drug classes or grouping of medications that are used to treat the same condition. There are preferred brand-name medications as well as generic medications listed on the PDL. The medications listed on the PDL are considered preferred drug choices as they provide the greatest economic value in the drug class. It is important to note that preferred medications are not chosen for inclusion on the PDL based on price alone; they are selected based on comparable clinical efficacy to other products in the same drug classes. The PDL undergoes a rigorous clinical and economic review annually. Medical specialists (physicians and pharmacists) evaluate any proposed changes to ensure they are consistent with the most recent and relevant clinical findings.

Medications in a 3-tier benefit structure are divided into 3 groups or copayment/coinsurance levels. Generic drugs are in the 1st tier copayment; certain brand-name drugs, including preferred brands, are in the 2nd tier copayment; and non-preferred brands are in the 3rd tier copayment. In most cases there are generic and/or preferred brand alternatives available for non-preferred brands. You should discuss the possibility of being prescribed a preferred brand or generic with your physician, if appropriate.

The PDL is available online at the CVS Caremark website or you may also call CVS Caremark Customer Care at **1-888-354-6390** to request a copy of the PDL and any updated information. The PDL is not distributed automatically to members when updated; to obtain the most recent copy, visit the CVS Caremark website or call CVS Caremark member services.

### **FORMULARY DRUG EXCEPTIONS**

CVS Caremark manages the formulary on behalf of CVT. CVT’s active and non-Medicare pharmacy plans utilize CVS Caremark’s standard formulary, with the exception of CVT’s ValuRx offering (see page 14 for plan details). As new drugs come to the market CVS Caremark evaluates their appropriateness and determines formulary access and tier placement. Please visit [www.caremark.com](http://www.caremark.com) or contact **Caremark Customer Care** at **1-888-354-6390** to determine if a drug is covered on the formulary and to check copayment.

### **QUANTITY LIMITS**

Quantity limits are defined as the maximum number of tablets or units (i.e. injections or nasal spray bottles) covered by the plan per copayment or coinsurance amount. These limits are established to ensure safety and appropriate utilization. Please call **Caremark Customer Care** at **1-888-354-6390** or visit the CVS Caremark website for details surrounding your specific drug coverage scenario.

### **COVERED MEDICATIONS**

- Legend medications (Federal law requires these medications to be dispensed by prescription only); see exceptions below.
- Diabetic Care: Insulin, test strips, lancets, disposable needles, and syringes are covered. Glucometers are not a covered item under the CVS Caremark prescription plan; however, CVS Caremark does offer the **Diabetic Meter Program**. This program offers a new, free meter every two years to eligible members; just call **1-800-588-4456** to receive your free meter. Not applicable to SilverScript Medicare Part D plans.
- Fertility medications up to a lifetime maximum of \$7,500 paid by CVT.

- Any other drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber.

#### **EXCLUDED MEDICATIONS**

- Certain cosmetic medications
- Hair growth products
- Levonorgestrel (Norplant)
- Medroxyprogesterone acetate (Depo-Provera)
- Pigmenting/Depigmenting agents
- Medical supplies and durable medical equipment
- Blood and blood plasma
- Cough and Cold products and other over-the-counter items
- Nutritional and dietary supplements
- Medical Devices
- Topical Analgesic/pain patch
- Bulk powders, compounding bases, and compounding kits
- Medications with an over-the-counter alternative
- Certain drugs that have limited clinical value and which have clinically appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs).
- Certain new drugs and new indications for existing drugs, approved by the U.S. Food and Drug Administration (FDA) after the plan effective date, that exceed a minimum cost-effectiveness threshold established by the plan unless the drug has been granted breakthrough therapy designation by the FDA. The plan threshold establishes a minimum value standard for prescription drugs measured by the benefit to patients through lengthening life or improving the quality of life. Visit [www.cvsspecialty.com/wps/portal/specialty](http://www.cvsspecialty.com/wps/portal/specialty) for information regarding specialty medications.
- Prescription digital therapies

Please note that the list of Excluded Medications is subject to change and you can obtain excluded medications and supplies at your own expense.

#### **COORDINATION OF BENEFITS**

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

CVT members with two pharmacy plans can process both their primary and secondary pharmacy claims at the retail pharmacy, or you may submit a paper claim to CVS Caremark to process the secondary coverage.

#### **ORDER OF BENEFITS DETERMINATION**

- If your spouse has prescription drug coverage from another carrier, that coverage must be used first. If your dependent child(ren) are covered by another carrier the 'birthday rule' will determine which plan must be used first. Call CVT Member Services Department at **1-800-288-9870** to establish primary and secondary coverage. Any balances should be submitted to CVS Caremark for consideration of payment.

- If your dependent does not have other prescription drug coverage, CVT requires a letter from the other insurance company or the employer stating that the coverage does not include prescription medications.
- If your dependent's prescription coverage is canceled for some reason, CVT will require a letter from the insurance company or the employer indicating the date of cancellation.
- When CVT is the secondary prescription drug coverage carrier, any balances should be submitted to CVS Caremark for consideration. Balances should be accompanied by a pharmacy receipt and statement from the other carrier (EOB) indicating what, if anything, was paid.
- Copays from other carriers can be submitted. Please indicate that these are copays on the form.
- If you or your dependent(s) have CVT primary and secondary prescription drug coverage, CVS Caremark's system will reflect your dual coverage status. If you are enrolled in CVT's Plan A, B, C, D or ValuRx with dual coverage CVS Caremark will process approved claims at \$0. If you are enrolled in CVT's Bronze, HDHP Plan 1, 2 or 3, CVS Caremark will process your approved claim according to the primary plan and you will need to submit a paper claim to process under the secondary coverage.
- Balances will be paid up to CVS Caremark allowances, i.e., if the cost of the drug is \$26.75 and CVS Caremark allows only \$23.00 for that particular drug; balances will be paid up to \$23.00.
- All balances should be submitted on a secondary coverage prescription drug claim form and should be mailed directly to CVS Caremark. These forms are available on CVT's website at [www.cvtrust.org](http://www.cvtrust.org).

#### **TERMINATION OF PHARMACY BENEFITS**

*Prescriptions filled for you and/or your dependents after termination date:*

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

**If you have other insurance at the time, please submit your claim or claims to them for reimbursement or have the pharmacy reverse the claim or claims and bill the proper insurance.** If you did not have other insurance, the claim is your responsibility and should be paid back to CVT, in full, immediately. CVT will contact you regarding reimbursement of the claim or claims. Any reimbursement not received within 45 days from the date of the notification letter, **will be forwarded to a collection agency.**

#### **CVT VALURX PRESCRIPTION PLAN**

The CVT ValuRx Prescription Plan is distinctive from CVT's other prescription plans in that it is heavily geared towards generic medications as a means to drive savings and offer groups real consumer choice. The plan includes the prescription features highlighted above with the following differences.

#### **PROXIMITY NETWORK**

Designed to save money for you and your plan while maintaining access for all, the pharmacies where you can fill your prescriptions are distinctive to this plan. If you live within 5 miles\* of a CVS/pharmacy, you must use CVS/pharmacy or Caremark Mail Service for all maintenance and non-maintenance prescriptions to avoid paying the full cost of your medication. CVS/pharmacy has over 9,600 stores nationwide, including those located inside Target stores. If you do not live within 5 miles\* of CVS/pharmacy, you will continue to have access to the national network of pharmacies, including most large drug store and grocery chains, along with many independent

pharmacies. The Maintenance Choice program outlined above, is applicable for all members including those that do not live within 5 miles of CVS/pharmacy.

For a complete pharmacy listing in your area, please visit [www.caremark.com](http://www.caremark.com) or call CVS Caremark at **1-888-354-6390**.

\* Note: Proximity to CVS/pharmacy is based on member's home zip code and geographical mileage, not driving directions.

## **VALUE FORMULARY**

The Value Formulary is a clinically comprehensive formulary covering all disease states and represents a closed formulary design. It is a two tier benefit plan that primarily covers generic medications and the most clinically-effective brands as determined through robust clinical evidence. In addition to changes to the medications covered, this plan may also have prior authorizations, quantity limits, and/or step therapy requirements that differ from the standard formulary options. Lifestyle medications such as those used for erectile dysfunction, anti-obesity, and cosmetic agents are covered at 100% member cost share. Infertility medications are excluded from this prescription plan coverage. "Dispense as Written" (DAW) costs do not apply to brands covered under this formulary.

## **VALUE FORMULARY RESOURCES**

*Value Formulary Quick Reference List:*

The Value Formulary Quick Reference List is not an all-inclusive list but represents a summary of prescribed medications within select therapeutic categories. This useful reference tool can assist medical providers in selecting therapeutically-appropriate and cost-effective products for their patients.

Visit [www.caremark.com/portal/asset/Value\\_Formulary\\_Quick\\_Reference\\_List.pdf](http://www.caremark.com/portal/asset/Value_Formulary_Quick_Reference_List.pdf), or you may also call **CVS Caremark Customer Care** at **1-888-354-6390** to request a copy and any updated information. The list is not distributed automatically to members when updated; to obtain the most recent copy, visit the CVS Caremark website or call CVS Caremark member services.

*CVS Caremark Value Formulary List:*

The Value Formulary is a useful reference and informational tool. This document can assist practitioners in selecting appropriate and cost-effective products for their patients. The information contained in this document and its appendices is provided solely for the convenience of medical providers. All the information in the document is provided as a reference for drug therapy selection. Specific drug selection for an individual patient rests solely with the prescriber. Visit [www.caremark.com/portal/asset/Value\\_Formulary.pdf](http://www.caremark.com/portal/asset/Value_Formulary.pdf) for a complete Value Formulary medication list.

*Value Formulary - Brand Medications Not Listed on Value Formulary:*

The Value Formulary covers select brand medications. Visit [http://www.caremark.com/portal/asset/Value\\_Formulary\\_Non-Listed\\_Brands.pdf](http://www.caremark.com/portal/asset/Value_Formulary_Non-Listed_Brands.pdf) for a list of select brand medicines that are most commonly used categories and are not listed on Value Formulary plans. These medicines are *not covered* under this formulary. If you are currently using one of the medicines not listed on your plan, ask

your doctor to consider one of the generic or brand options included on this list. If you continue using one of these medication without authorization, you may be required to pay up to the full cost of the medicine.

*CVS Caremark Value Formulary Plan Website:*

Members and prescribers can visit [www.info.caremark.com/highvalueplan](http://www.info.caremark.com/highvalueplan) to learn more about this cost effective, clinically appropriate formulary, including FAQs to assist with coverage questions.

## **SILVERSCRIPT: MEDICARE PART D PRESCRIPTION COVERAGE**

SilverScript is the prescription drug plan for CVT participants who are eligible for Medicare. SilverScript is offered by SilverScript® Insurance Company which is affiliated with CVS Caremark®.

The plan combines the benefits of a standard Medicare Part D prescription drug plan with additional coverage provided by CVT to expand the Part D benefits. As a result of this combined coverage, your coverage will be similar to the prescription drug coverage for pre-Medicare participants and you will have more coverage than the standard Medicare Part D plan. For a complete list of prescription coverage visit [www.cvtrust.org/resources/silverscript](http://www.cvtrust.org/resources/silverscript) for the specific plan Evidence of Coverage (EOC) located under CVT Plan Features and Information.

## **CLAIMS REVIEW**

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

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

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

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

## **RECONSIDERATIONS**

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

## **APPEALS**

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

- a. **Review of Benefit Coverage.** Caremark shall conduct appeals relating to eligibility and coverage. Such reviews will be based on the Plan Document provisions and criteria approved by the Plan, with respect to coverage of prescription drug benefits only, and shall not include a review of medical necessity as may be defined under the terms of the Plan Document. With respect to such review of benefit coverage, Caremark shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of Caremark shall be final, subject to any External Review, outlined below. Caremark may, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the Plan Document. Under the Appeals Program, Caremark agrees to be a fiduciary solely for the purpose of adjudicating appeals relating to the coverage of prescription drug benefits. Caremark will review appeals in accordance with the rules and procedures established by Caremark to govern appeals from the denials of claims, as may be amended from time to time.
  
- b. **Review of Medical Necessity.** Caremark has contracted with an independent vendor or vendors for the processing of appeals resulting from a denial of authorization of prescription benefits where the Plan beneficiary is entitled to obtain a review of the denial by a physician specialist. Caremark has entered or will enter into an agreement with the independent vendor(s), which provides for an appeals process consistent with the Appeals Program. The decision of the independent vendor shall be final, subject to External Review, outlined below, or available review only for abuse of discretion as established by the Plan and set forth in this Benefit Booklet.

*Reconsideration or appeals:*

You or your authorized representative (i.e. the prescribing physician) may submit an appeal in writing to the pharmacy benefit administrator at:

**Prescription Claim Appeals, MC109  
CVS Caremark  
PO Box 52084  
Phoenix, AZ 85072-2084  
FAX: (866) 689-3092**

Requests must be made as follows:

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

Requests must include the following:

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

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

*Voluntary second level appeals:*

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

**EXTERNAL REVIEW**

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

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

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

**Prescription Claim Appeals, MC109  
CVS Caremark  
PO Box 52084  
Phoenix, AZ 85072-2084  
FAX: (866) 689-3092**

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

**BINDING ARBITRATION**

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

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

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

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

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

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

## DEFINITIONS

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

**CVT** is the California's Valued Trust.

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

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

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

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

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

**Member** is the subscriber or family member.

**Out of network pharmacy** is a pharmacy which is not part of the pharmacy benefit manager's network

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

Remember that the maximum allowed amount may only represent a portion of the amount which an out of network pharmacy charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

**Network Pharmacy** is a pharmacy which is part of the pharmacy benefit manager's network:

Network pharmacies agree to accept the maximum allowed amount as payment for covered services. A directory of participating pharmacies can be found at Caremark.com or by contacting Caremark member services

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

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

**Proximity network** is the network utilized for the CVT ValuRx pharmacy plan.

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

**Value formulary** is the formulary utilized for the CVT ValuRx pharmacy plan.

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

## GET HELP IN YOUR LANGUAGE

### English

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help (TTY/TDD: 711)

### Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda (TTY/TDD: 711)

### Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك (للمساعدة) (TTY/TDD: 711)

### Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

### Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

### Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی تان درج شده است، تماس بگیرید (TTY/TDD: 711)

### Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मु\_त\_ा\_त करने का अ\_धकार है। मदद के \_लए अपने ID काड# पर सद\$य सेवाँ नंबर पर कॉ\_ि कर\_। (TTY/TDD: 711)

### Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD:711)

### Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

**Khmer**

អ្នកស្វែងរកព័ត៌មាន និងទំនួលខុសត្រូវរបស់អង្គការយុវជនកម្ពុជា។ សូមទំនួលខុសត្រូវសម្រាប់សេវាសម្រាប់អ្នកដែលមានលេខ ID របស់អង្គការយុវជនកម្ពុជា (TTY/TDD: 711)

**Korean**

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

**Punjabi**

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਫ਼ਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਮੈਂਬਰ ਸੇਵਾ ਵਸਤੂ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

**Russian**

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

**Tagalog**

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

**Thai**

ท่านมีสิทธิขอรับบริการสอบถามข้อ มูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปท&#o228;มายเลขฝั ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อ&#o228;ขอความช่วยเหลือ (TTY/TDD: 711)

**Vietnamese**

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để đư&#o228;ợc giúp đỡ. (TTY/TDD: 711)

**It’s important we treat you fairly**

Federal civil rights laws prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, age, disability, or sex. The laws apply to health programs and activities that receive funding from the Federal government, are administered by a Federal agency or are offered on a public Health Insurance Marketplace. Health plans that are subject to the laws include Medicare Part D plans, Medicaid plans, health plans offered by issuers on Health Insurance Marketplaces, and certain employee health benefit plans. If you have

questions about whether these Federal civil rights laws apply to your plan, please contact your health plan at the number in your benefit plan materials.

If your health plan is subject to these Federal civil rights laws, it complies with the laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

- Provides appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us, such as:
  - Auxiliary aids and services
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe these services have not been appropriately provided to you or you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email with your health plan's Civil Rights Coordinator.

You may also contact Customer Care and we will direct your grievance to your health plan's Civil Rights Coordinator:

Nondiscrimination Grievance Coordinator  
PO BOX 6590, Lee's Summit, MO 64064-6590  
Phone: 1-866-526-4075  
TTY: 1-800-863-5488  
Fax: 1-855-245-2135  
Email: nondiscrimination@cvscaremark.com

If you need additional help filing a grievance, your health plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil

Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>