



2018 PLAN YEAR



# IU Prescription Plan

Summary of Plan Provisions

Prescription Drug Coverage Administered by CVS Caremark

## Foreword

This Prescription Benefit document describes how to get prescription medications, what medications are covered and not covered, and what portion of the prescription costs you will be required to pay.

CVS Caremark, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit under a contract with Indiana University (the Plan). CVS Caremark maintains the Preferred Drug list (also known as a Formulary), manages a network of retail pharmacies, and operates the Mail Service and Specialty Drug pharmacies. CVS Caremark, in consultation with the Plan, also provides services to promote the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions, and other safety measures.

Employees and dependents covered by Indiana University's prescription drug benefit can use either retail pharmacies or the CVS Caremark Mail Service Pharmacy. The benefit covers most prescription drugs and some OTC items considered preventive under the Health Care Reform Act. Certain medications are subject to limitations and may require prior authorization for continued use.

## Obtaining Your Prescriptions

### Retail Pharmacies

Retail pharmacy service is most convenient for short-term prescription needs. At retail, you can get up to a 30-day supply, or up to a 90-day supply of maintenance medications at CVS retail pharmacies. The CVS Caremark pharmacy network includes most retail chain pharmacies and supermarket pharmacy chains. Some independent pharmacies are also included. *Walgreens is not part of the network for Indiana University plans.* To locate network pharmacies, visit [Caremark.com](http://Caremark.com) or call 866-234-6952.

### Mail Service Pharmacy

Members who need non-specialty medications on an ongoing basis can ask their doctor to prescribe up to a 90-day supply, plus refills if appropriate. Examples are ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. Just a single charge is required for each 90-day prescription. Medications are shipped standard delivery at no additional cost, and may also include instructions for ordering refills, information about the purpose of the medication, appropriate dosage guidelines, and other important details. You can track your prescriptions and order refills at [Caremark.com](http://Caremark.com) or by calling 866-234-6952. Registered pharmacists are available around the clock for consultation.

### Specialty Pharmacy

CVS Caremark has a separate arrangement for specialty medications through CVS Specialty. Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Many of these medications are high cost and may require special handling. Members are able to receive a 30-day supply of specialty medications at a time. For more information on specialty medications, visit [CVSSpecialty.com](http://CVSSpecialty.com) or call 800-237-2767.

***The benefits described in this booklet are effective as of January 1, 2018.***

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## How to Obtain Prescription Drug Benefits

How you obtain your benefits depends on whether you go to a network or non-network pharmacy.

### Network Retail Pharmacy

The retail pharmacy network includes the following chains: CVS, Wal-Mart, Sam's Club, Target, Kroger, KMart, and more. *Walgreens is not part of the network for Indiana University plans.* To search for participating pharmacies in the CVS Caremark retail network, visit [Caremark.com](https://www.caremark.com) or call 866-234-6952.

To fill your prescription at a network retail pharmacy, present your written prescription from your physician and your ID card to the pharmacist. Alternatively, some physicians send prescriptions to pharmacies electronically, in which case you will only need to present your ID card. You will be charged at the point of purchase for applicable deductible and/or copayment/coinsurance amounts, and the pharmacy will submit your claim for you.

If you do not present your ID card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to CVS Caremark using the [Prescription Reimbursement Claim Form](#).

### CVS Caremark Mail Service Pharmacy

Through Mail Service, you may receive up to a 90-day supply of many non-specialty maintenance medications.

To begin Mail Service delivery, complete the [CVS Caremark Mail Service Order Form](#) and Questionnaire. You may mail written prescriptions from your physician, or have your physician fax or send the prescription electronically to CVS Caremark.

You will need to submit the applicable deductible, co-insurance and/or copayment amounts to CVS

#### Maintenance Medication

Drugs generally taken on a long-term basis for conditions such as high blood pressure and high cholesterol. Long-term drugs are those taken on an ongoing basis, such as those used to treat high blood pressure or high cholesterol. Short-term drugs include antibiotics and other medications that you take for short periods of time.



Caremark when you request a prescription or refill.

Medications are shipped standard delivery at no additional cost. You can track your prescriptions and order refills at [Caremark.com](https://www.caremark.com) or by calling 866-234-6952. Registered pharmacists are available around the clock for consultation.

### Specialty Drugs

Specialty medications are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis.

CVS Specialty offers therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

CVS Specialty must be used to fill specialty drug prescription orders, subject to a 30-day supply, with the applicable coinsurance or copayment shown in the Schedule of Benefits.

Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the Member may not receive credit toward their maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

For more information or to order your specialty medications, visit [CVSspecialty.com](https://www.cvs.com/specialty) or call CVS Specialty at 800-237-2767.

### Out-of-Network Retail Pharmacy

If you visit a non-network retail pharmacy, you are responsible for payment of the entire amount charged by the non-network retail pharmacy and will then need to submit a [Prescription Reimbursement Claim Form](#) to CVS Caremark for reimbursement consideration.

You must complete the form, attach an original itemized receipt to the claim form, and submit to CVS Caremark. The itemized receipt must show:

- Pharmacy name and address or Pharmacy NABP number
- Patient's name
- Prescription number
- Date the prescription was filled
- Medicine NDC number (drug number)
- Metric quantity

- Total charge
- Day's supply for your prescription
- Prescribing physician's NPI (National Provider Identification) number

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by CVS Caremark's normal or average contracted rate with network pharmacies on or near the date of service.

## Covered Services

### Prior Authorization

Prior Authorization may be required for certain prescription drugs (or the prescribed quantity of a particular drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage.

At the time you fill a prescription, the pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. CVS Caremark may contact your provider if additional information is required to determine whether Prior Authorization should be granted. CVS Caremark communicates the results of the decision to both you and your provider.

If Prior Authorization is denied, written notification is sent to both you and your providers. You have the right to appeal through the appeals process. The written notification of denial you receive provides instructions for filing an appeal.

You, your provider, or pharmacist, may check with CVS Caremark to verify covered prescription drugs, any quantity and/or age limits, prior authorization, or other requirements.

To ask if a drug requires Prior Authorization, please contact CVS Caremark at the Customer Service telephone number on the back of your ID card.

### Formulary or Preferred Drug List

A formulary is a list of commonly prescribed medications from which your physician may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other non-formulary medications, can help contain the increasing cost of prescription drug coverage while maintaining the high quality of care.

You may request a copy of the preferred drug list or formulary by calling CVS Caremark at the Customer Service telephone number on the back of your ID card or view the list online at [Caremark.com](https://www.caremark.com). The preferred drug list is subject to periodic review and amendment and the inclusion of a drug or related item on the preferred drug list is not a guarantee of coverage.

CVS Caremark may contact you or your prescribing physician to make you aware of preferred alternatives. Therapeutic interchange may also be initiated at the time the prescription is dispensed. The therapeutic interchange drug list is subject to periodic review and amendment. No change in the medication prescribed for you will be made without you, or your physicians' approval.

For questions or issues involving therapeutic drug substitutes, contact CVS Caremark at 866-234-6952.

### Step Therapy

Step therapy protocol means that a member may need to use one type of medication before another. If physician approved, the more cost-effective medication will be dispensed. If the physician does not approve and prefers a non-preferred drug, prior authorization is needed.

### Specialty Pharmacy Network

"Specialty Drugs" are (A) used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis; (B) Are typically injected, infused or require close monitoring by a physician or clinically trained individual; or (C) Have limited availability, special dispensing and delivery requirements, and/or require additional patient support. CVS Specialty offers:

- Expedited scheduled delivery to the location you choose (your home, doctor's office, outpatient clinic), and free supplies to administer your medication (e.g., needles, syringes).
- Individualized support from trained nurses and patient care representatives.
- 24/7 access to registered pharmacists for questions.

CVS Specialty must be used to fill specialty drug prescription orders, subject to a 30-day supply, with the applicable coinsurance or copayment shown in the Schedule of Benefits. For more information or to order specialty medications, call 800-237-2767.

## Covered Prescription Drug Benefits

Prescription drugs, unless otherwise stated below, must be medically necessary and not experimental/investigative, in order to be Covered Services. For certain prescription drugs, the prescribing physician may be asked to provide additional information before CVS Caremark and/or the Plan can determine medical necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific prescription drugs.

Covered Services will be limited based on medical necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Covered Prescription drug benefits include:

- Prescription legend drugs
- Certain OTC medications as indicated under the Affordable Care Act\*
- Injectable insulin and needles and syringes used for administration of insulin
- Non-insulin needles and syringes
- Contraceptive drugs: oral, transdermal, intravaginal, and injectable
- Contraceptive devices
- Prescription vitamins including prescription fluoride supplements as well as those covered under the Affordable Care Act\*
- Influenza immunizations
- Immunizations covered under the Affordable Care Act\*
- Certain supplies and equipment are covered such as diabetic test strips, lancets, swabs, glucose monitors, and inhaler spacers. If certain supplies, equipment or appliances are not available through the prescription benefit, they may be available through the medical benefit.
- Injectables unless otherwise noted as benefit exclusions
- Prescription medical foods such as nutritional

### Prescription Legend Drug or Prescription Drug

A medicinal substance that is produced to treat illness or injury and is dispensed to patients. Under the Federal Food, Drug, & Cosmetic Act, such substances must bear a message on its original packing label that states, Caution: Federal law prohibits dispensing without a prescription.



## Learn More Online



- [Caremark.com](https://www.caremark.com)  
Create an account to find a network pharmacy, research drug prices, and more.
- [CVS Caremark Publications/Forms](#)  
View the Drug Formulary, list of Specialty Medications, and download the Prescription Drug Claim Form.

supplements, infant formulas, supplements for inherited metabolic diseases (including PKU)

- Prescription and some OTC smoking cessation drugs\*\*

## Non-Covered Prescription Drug Benefits

Non-Covered Prescription drug benefits include:

- Over the counter drugs and vitamins, except insulin and those covered under the Affordable Care Act\*
- Estriol compounds
- Medications used for cosmetic purposes only such as hair growth stimulants
- Allergy sera
- Blood and blood plasma products except for hemophilia factors
- Experimental/ Investigative Drugs
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause
- Drug treatment related to infertility
- Compounds
- Over the counter homeopathic or herbal medicines

\* Certain prescription and OTC medications are considered preventative by the Affordable Care Act and are covered by the benefit. A prescription is required to obtain these preventative medications through your prescription benefit.

\*\* Tobacco cessation prescriptions and nicotine replacement products considered preventative are covered 100% (no deductible). For an individual, the maximum allowable benefit for tobacco-cessation medications on your preventive prescription drug list filled at retail or mail service pharmacies is a 168 day supply every year. After you reach the drug specific maximum allowable preventive benefit, the deductible will apply.

If your medication is in a category not covered by the prescription drug benefit, please check with your medical carrier as it may be covered by that benefit.

### Copayment & Coinsurance

The copayment or “copay” is a fixed amount paid for a covered service.



Coinsurance is the member’s share of the cost of a covered service. For example, if the plan pays 80%, the member’s coinsurance is 20%.

### Deductible/Coinsurance/Copayment

Each prescription order may be subject to a deductible and coinsurance/copayment. If the prescription order includes more than one covered drug, a separate coinsurance/copayment will apply to each drug.

The amount you pay for your prescription drugs will be no less than the minimum copay (unless the usual and customary retail price is less than the minimum copay) and it will be no more than the lesser of your scheduled copayment/coinsurance amount or the Maximum Allowable Amount.

Please see the Schedule of Benefits for any applicable deductible and coinsurance/copayment. You are responsible for all deductibles and/or copayment/coinsurance amounts. If you receive Covered Services from a non-network pharmacy, a separate deductible and coinsurance/copayment amount may also apply.

Your copayment, coinsurance and/or deductible amounts will not be reduced by any discounts, rebates or other funds received by CVS Caremark from drug manufacturers or similar vendors.

### Day’s Supply

The number of day’s supply of a drug that you may receive is limited. The day’s supply limit applicable to prescription drug coverage is shown in the Schedule of Benefits. Day’s supply may be less than the amount shown in the Schedule of Benefits due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

If you are going on vacation and you need more than the day’s supply allowed for a retail prescription under this Plan, talk with your retail pharmacist. If your prescription is through mail service, call CVS Caremark Mail Service Pharmacy and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your ID card.

### Tiers

CVS Caremark classifies prescriptions by tiers: generic (Tier 1), preferred (Tier 2) and non-preferred (Tier 3). In a traditional medical plan (i.e. not an HDHP plan), your copayment/coinsurance amount may vary based on what tier the prescription drug has been classified by the Plan, including covered Specialty Drugs.

The determination of tiers is made based upon clinical information, and, where appropriate, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, and certain clinical economic factors.

Tier	Drug Type	Cost
1	Generally includes <b>generic</b> prescription drugs.	\$
2	Generally includes <b>preferred brand name</b> or generic drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other drugs.	\$\$
3	Generally includes <b>non-preferred brand name</b> or generic drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other drugs in lower tiers.	\$\$\$

For High Deductible Health Plans (HDHPs) the deductible/coinsurance amount does not vary based on tiers.

### Payment of Benefits

The amount of benefits paid is based upon whether you receive the drug from a retail pharmacy, Mail Service Pharmacy, Specialty Pharmacy, or a non-network retail pharmacy. It is also based upon the Tier classification for the prescription drug or specialty drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply. The Plan retains the right at its discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable deductible and/or copayment/coinsurance for which you are responsible.

## What is the Difference Between Brand and Generic Drugs?

### Brand Drug

The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

### Generic Drug

Prescription drugs that have been determined by the FDA to be equivalent to brand name drugs, but are not made or sold under a registered trade name or trademark. Generic drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency, and must be dispensed in the same dosage form (tablet, capsule, cream) as the brand name drug.



## Schedule of Benefits

The Schedule of Benefits is a summary of the deductibles, maximums, and other limits that apply to services obtained from a provider. Please refer to the "Covered Services" section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All covered services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet.

**Plan Year:** Benefits are based on a calendar Plan Year, January 1 to December 31.

**Dependent Age Limit:** Age 25 or under (eligibility ends at the end of the month in which the child reaches age 26), unless the Dependent qualifies for Disabled Child Eligibility.

**Lifetime Maximums:** None

**Pre-Existing Condition Limitations:** None

## IU Health High Deductible Health Plan (IU Health HDHP)

Service	In-Network - Member Pays	Out-of-Network - Member Pays
<b>Retail Prescriptions</b> (Up to 30-day supply) or (90-day supply at CVS Pharmacies)	20% coinsurance after deductible <sup>1</sup>  No coinsurance or deductible on most contraceptives	No Coverage
<b>Mail Service</b> Maintenance Drugs (Up to 90-day supply) Specialty Drugs <sup>2</sup> (Up to 30-day supply)	Specialty Drugs <sup>2</sup> are not covered at Retail	

**Deductible** (combined In-Network R<sub>x</sub> + Medical):

- \$2,500 employee-only/\$5,000 all other coverage levels
- Prescription drug copayments/coinsurance are subject to the deductible

**Out-of-Pocket Limit** (combined In-Network R<sub>x</sub> + Medical):

- \$3,000 employee-only/\$6,000 all other coverage levels
- Prescription drug copayments/coinsurance are subject to the out-of-pocket limit; once the member and/or family out-of-pocket limit is satisfied, no additional copayments/coinsurance are required for the remainder of the calendar year.

<sup>1</sup> No deductible on preventive prescriptions. For drug list, visit [hr.iu.edu/benefits/rx.html](http://hr.iu.edu/benefits/rx.html).

<sup>2</sup> Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused - only covered through CVS Specialty.

## Anthem PPO \$500 Deductible (Anthem PPO \$500)

Service	In-Network - Member Pays	Out-of-Network - Member Pays
<b>Tier 1</b> (Generic Drugs <sup>1</sup> )	Retail (30-day supply): <b>\$8</b> Retail at CVS Pharmacies (90-day supply): <b>\$20</b> Mail Service (90-day supply): <b>\$20</b>	50% coinsurance plus amounts above the network's discounted price  No Coverage for Out-of-Network Mail Service
<b>Tier 2</b> (Preferred Brand Drugs)	Retail (30-day supply): <b>\$25</b> Retail at CVS Pharmacies (90-day supply): <b>\$62</b> Mail Service (90-day supply): <b>\$62</b>	
<b>Tier 3</b> (Non-Preferred Brand Drugs)	Retail (30-day supply): <b>\$45</b> Retail at CVS Pharmacies (90-day supply): <b>\$112</b> Mail Service (90-day supply): <b>\$112</b>	
<b>Specialty Drugs<sup>2</sup></b> (30-day supply)	Tier 1 (Generic <sup>1</sup> ): <b>\$20</b> Tier 2 (Preferred Brand): <b>\$62</b> Tier 3 (Non-Preferred Brand): <b>\$112</b>	No Coverage

Three-tier Prescription Copayments: *Within the brand and generic categories drugs are assigned a copayment "tier" based on cost and therapeutic value compared to other drugs. Tier 1 drugs are generics; Tier 2 are preferred brands; Tier 3 drugs include non-preferred brand drugs.*

### Deductible

- No deductible applies
- No copayment or deductible on most contraceptives

### Out-of-Pocket Limit (In-Network Rx Only)<sup>3</sup>

- \$4,250 employee-only/\$6,100 all other coverage levels

- 1 For a brand drug with a generic version available: member pays generic copayment plus the cost difference between the brand and generic.
- 2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These only covered through CVS Specialty.
- 3 Medical expenses do not count toward prescription out-of-pocket maximum

## Anthem PPO High Deductible Health Plan (Anthem PPO HDHP)

Service	In-Network - Member Pays	Out-of-Network - Member Pays
<b>Retail Prescriptions</b> (Up to 30-day supply) or (90-day supply at CVS Pharmacies)	20% coinsurance after deductible <sup>1</sup>  No coinsurance or deductible on most contraceptives	40% after deductible
<b>Mail Service</b> Maintenance Drugs (Up to 90-day supply) Specialty Drugs <sup>2</sup> (Up to 30-day supply)	Specialty Drugs <sup>2</sup> are not covered at Retail	No Coverage

### Deductible (combined In-Network Rx + Medical):

- \$1,350 employee-only/\$2,700 all other coverage levels
- Prescription drug copayments/coinsurance are subject to the deductible

### Out-of-Pocket Limit (combined In-Network Rx + Medical):

- \$2,700 employee-only/\$5,400 all other coverage levels
- Prescription drug copayments/coinsurance are subject to the out-of-pocket limit; once the member and/or family out-of-pocket limit is satisfied, no additional copayments/coinsurance are required for the remainder of the calendar year.

1 No deductible on preventive prescriptions. For drug list, visit [hr.iu.edu/benefits/rx.html](http://hr.iu.edu/benefits/rx.html).

2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused - only covered through CVS Specialty.

## Anthem IU Resident Plan

Service	In-Network - Member Pays	Out-of-Network - Member Pays
<b>Retail Prescriptions</b> (Up to 30-day supply)	Tier 1: <b>\$10</b> Tier 2: <b>\$25</b> Tier 3: <b>\$75</b>	50% coinsurance plus amounts above the network's discounted price
<b>Mail Service</b> Maintenance Drugs (Up to 90-day supply) Specialty Drugs <sup>2</sup> (Up to 30-day supply)	Tier 1: <b>\$25</b> Tier 2: <b>\$60</b> Tier 3: <b>\$180</b>	No Coverage

Three-tier Prescription Copayments: *Within the brand and generic categories drugs are assigned a copayment "tier" based on cost and therapeutic value compared to other drugs. Tier 1 drugs are generics; Tier 2 are preferred brands; Tier 3 drugs include non-preferred brand drugs.*

### Deductible

- No deductible applies
- No copayment or deductible on most contraceptives

### Out-of-Pocket Limit (In-Network Rx only)<sup>3</sup>

- \$5,250 employee-only/\$9,100 family

- 1 For a brand drug with a generic version available: member pays generic copayment plus the cost difference between the brand and generic.
- 2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These only covered through CVS Specialty.
- 3 Medical expenses do not count toward prescription out-of-pocket maximum

## Anthem GA PPO Plan

Service	In-Network - Member Pays	Out-of-Network - Member Pays
<b>Retail Prescriptions</b> (Up to 30-day supply)	Tier 1: <b>\$8</b> Tier 2: <b>\$25</b> Tier 3: <b>\$45</b>	50% coinsurance plus amounts above network discounted price
<b>Mail Service</b> Maintenance Drugs (Up to 90-day supply) Specialty Drugs <sup>2</sup> (Up to 30-day supply)	Tier 1: <b>\$20</b> Tier 2: <b>\$62</b> Tier 3: <b>\$112</b>	No Coverage

Three-tier Prescription Copayments: *Within the brand and generic categories drugs are assigned a copayment "tier" based on cost and therapeutic value compared to other drugs. Tier 1 drugs are generics; Tier 2 are preferred brands; Tier 3 drugs include non-preferred brand drugs.*

### Deductible

- No deductible applies
- No copayment or deductible on most contraceptives

### Out-of-Pocket Limit (In-Network Rx only)<sup>3</sup>

- \$4,650 employee-only/\$9,300 family

- 1 For a brand drug with a generic version available: member pays generic copayment plus the cost difference between the brand and generic.
- 2 Specialty Drugs are high cost, scientifically engineered drugs that are usually injected or infused. These only covered through CVS Specialty.
- 3 Medical expenses do not count toward prescription out-of-pocket maximum

## Definitions

### Coinsurance

The member's share of the cost of a covered service. For example, if the plan pays 80%, the member's coinsurance is 20%.

### Copayment

The copayment or "copay" is a fixed amount paid for a covered service. Coinsurance is the member's share of the cost of a covered service. For example, if the plan pays 80%, the member's coinsurance is 20%.

### Deductible

The dollar amount of covered services an individual must pay each plan year before the plan begins reimbursement.

### Mail Service

A convenient means of obtaining maintenance medications by mail. Covered prescription drugs are ordered directly from the licensed Mail Service Pharmacy, and sent directly to your home.

### Member

Any person covered under the plan, including the employee, a spouse, or a child. Sometimes also referred to as enrollee or participant.

### Network Specialty Pharmacy

A pharmacy that has entered into a contractual agreement or is otherwise engaged by the plan to render Specialty Drug services, or with another organization that has an agreement with the plan, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy network.

### Pharmacy

An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a physician's order. A pharmacy may be a network provider or a non-network provider.

### Prescription Order

A legal request, written by a provider, for a prescription drug or medication and any subsequent refills.

### Specialty Drugs

High cost medications used to treat chronic, complex, and/or rare disease states generally requiring clinical assessment to optimize safety and adherence. Specialty drugs are often, but not only, given by injection or infusion, and may require special handling, storage, and/or administration. These drugs are covered only through CVS Specialty Pharmacy.

## Grievance & Appeals Procedure

To formally lodge a complaint with CVS Caremark, call 866-234-6952. Your initial response will be addressed by a Customer Service Representative.

Your concerns will be logged into CVS Caremark's Customer Service Contact System. Unresolved complaints will be escalated to a customer service resolution expert or to a supervisor. You can also request that your issue be escalated.

If your issue is still not resolved to your satisfaction, you have the right to file a formal appeal either verbally by phone, by mail, or by fax.

You will receive a follow-up phone call and/or letter regarding resolution of your issue.

### Telephone

File an appeal verbally at 866-234-6952.

### Fax

File appeals via fax at 866-443-1172.





# Indiana University Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Effective Date:** April 14, 2003

**Updated:** October 23, 2017

As the Plan Sponsor of employee health care plans, Indiana University is required by law to maintain the privacy and security of your individually identifiable health information. We protect the privacy of that information in accordance with federal and state privacy laws, as well as the university's policy. We are required to give you notice of our legal duties and privacy practices, and to follow the terms of this notice currently in effect.

This notice applies to all employees covered under an IU-sponsored health plan, but particularly those enrolled in IU self-funded plans.

## **How The Plan May Use and Disclose Protected Health Information about Members**

Protected Health Information (PHI) is health information that relates to an identified person's physical or mental health, provision of health care, or payment for provision of health care, whether past, present or future and regardless of the form or medium, that is received or created by the Plan in the course of providing benefits under these Plans.

The following categories describe different ways in which Indiana University uses and discloses health information. For each of the categories Indiana University has provided an explanation and an example of how the information is used. Not every use or disclosure in a category will be listed. However, all of the ways Indiana University is permitted to use and disclose information will fall within one of the categories

### **Treatment**

Health information may be reviewed to provide authorization of coverage for certain medical services or shared with providers involved in a member's treatment. For example, the Plan may obtain medical information from or give medical information to a hospital that asks the Plan for authorization of services on the member's behalf, or in conjunction with medical case management, disease management, or therapy management programs.

### **Payment**

Medical information may be used and disclosed to providers so that they may bill and receive payment for a member's treatment and services. For example, a member's provider may give a medical diagnosis and procedure description on a request for payment made to the Plan's claim administrator; and the claim administrator may request clinical notes to determine if the service is covered. Similarly, a physician may submit medical information to a Business Associate for purposes of administering wellness program financial incentives. Medical information may also be shared with other covered entities for business purposes, such as determining the Plan's share of payment when a member is covered under more than one health plan.

Explanations of Payments are also mailed to the address of record for the employee, the primary insured.

### **Health Care Operations**

Health information may be used or disclosed when needed to

administer the Plan. For example, Plan administration may include activities such as quality management, administration of wellness programs and incentives, to evaluate health care provider performance, underwriting, detection and investigation of fraud, data and information system management; and coordination of health care operations between health plan Business Associates. Genetic information will not be used or disclosed for health plan underwriting purposes.

Medical information may also be used to inform members about a health-related service or program, or to notify members about potential benefits. For example, we may work with other agencies or health care providers to offer programs such as complex or chronic condition management.

### **Individuals Involved in Your Care or Payment of Care**

Unless otherwise specified, the plan may communicate health information in connection with the treatment, payment, and health care operations to the employee and/or any enrolled individual who is responsible for either the payment or care of an individual covered under the plan. Also, when a member authorizes another party in writing to be involved in their care or payment of care, the Plan may share health information with that party. For example, when an employee signs an authorization allowing a close friend to make medical decisions on his or her behalf, the Plan may disclose medical information to that friend.

### **Legal Proceedings, Government Oversight, or Disputes**

Health information may be used or disclosed to an entity with health oversight responsibilities authorized by law, including HHS oversight of HIPAA compliance. For example, we may share information for monitoring of government programs or compliance with civil rights laws. Health information may also be disclosed in response to a subpoena, court or administrative order, or other lawful request by someone involved in a dispute or legal proceeding.

### **Research**

Health information may be used or shared for health research. Use of this information for research is subject to either a special approval process, or removal of information that may directly identify you.

## **Uses and Disclosures Requiring Your Written Authorization**

In all situations, other than the categories described above, we will ask for your written authorization before using or disclosing personal information about you. The Plan will not share member information for marketing purposes, including subsidized treatment communications, or the sale of member information without written permission. Members can also opt-out of fundraising communications with each solicitation. If you have given us an authorization, you may revoke it at any time. This revocation does not apply to any uses or disclosures already made in reliance on the authorization.

Mental health information, including psychological or psychiatric treatment records, and information relating to communicable diseases are subject to special protections under Indiana law. Release of such records or information requires written authorization or an appropriate court order.

## **Member Rights Regarding Protected Health Information**

### **Right to Inspect and Copy**

Members have the right to inspect and obtain a copy of the Protected Health Information maintained by the Plan including medical records and billing records

To inspect and copy PHI, members must submit in writing a request to the plan administrator. Requests to inspect and copy PHI may be denied under certain circumstances. If a member's request to inspect and copy has been denied written documentation stating the reason for the denial will be sent to the member.

### **Right to Amend**

Members have the right to request an amendment to PHI if they feel the medical information is incorrect for as long as the information is maintained.

To request an amendment, members must submit requests, along with a reason that supports the request, in writing to the plan administrator.

The Plan may deny a member's request for an amendment if it is not in writing or does not include a reason to support the request. Additionally, the Plan may deny a member's request to amend information that:

- Is not part of the information in which the member would be permitted to inspect or copy;
- Is not part of the information maintained by the Plan
- Is accurate and complete

### **Right to an Accounting of Disclosures**

Members have the right to an accounting of PHI disclosures during the six years prior to the date of a request.

To request an accounting of disclosures, members must submit requests in writing to the plan administrator. Requests may not include permitted PHI disclosures made to carry out treatment, payment or health care operations included in the six categories listed above. The member's written request must include a date or range of dates and may not include any dates before the April 14, 2003, compliance date.

### **Right to Request Restrictions**

Members have the right to request restrictions on certain uses and disclosures of Protected Health Information to carry out treatment, payment or health care operations. Members also have the right to request a limit on the information the Plan discloses to someone who is involved in the payment of your care; for example: a family member covered under the plan.

The Plan is not required to agree to your request. To request restrictions, members must submit requests in writing to the Plan. Requests must include the following: (1) information the member wants to limit; (2) whether the member wants to limit our use, disclosure or both; and (3) to whom the member wants the limit to apply, for example, disclosures to a spouse.

### **Right to Request Confidential Communications**

Members have the right to request that the Plan communicate with them about health information in a certain way or at a certain location. For example, asking that the Plan contact a member only at work.

To request confidential communications, members must submit requests in writing to the health plan administrator and must include where and how members wish to be contacted.

The Plan will accommodate all reasonable requests.

### **Right to Receive Breach Notification**

If the Plan components or any of its Business Associates or the Business Associate's subcontractors experiences a breach of health information (as defined by HIPAA laws) that compromises the security or privacy of health information, members will be notified of the breach and any steps members should take to protect yourself from potential harm resulting from the breach.

### **Right to a Copy of This Notice**

Members have the right to a copy of this Notice by e-mail. Members also have the right to request a paper copy of this notice. To obtain a copy, please contact the Privacy Administrator or visit <http://hr.iu.edu/benefits/privacynotice.pdf>.

### **Changes Made to This Notice**

The Plan reserves the right to change this Notice. The Plan reserves the right to make the revised or changed notice effective for Protected Health Information the Plan already has about members as well as any information received in the future. The new notice will be available on our web site, upon request, or by mail.

### **Right to File a Complaint**

If a member believes that their privacy rights have been violated, they may file a complaint to the Privacy Administrator with Indiana University's Health Care Plans, see contact information below.

Members may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue S.W., Washington, D.C., 20201; calling 1-877-696-6775, or visiting <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.

Indiana University will not retaliate against any member for filing a complaint.

## **Contact Information**

Members may contact the health plan with any requests, questions or complaints. We will respond to all inquiries within 30 days after receiving a written request. The Plan will accommodate all reasonable requests.

Privacy Administrator  
Poplars E165  
400 E. Seventh Street  
Bloomington, Indiana 47405-3085  
812-856-1234  
[askHR@iu.edu](mailto:askHR@iu.edu)

## **Personal Representatives**

Members may exercise their rights through a personal representative. This person will be required to produce evidence of his/her authority to act on a member's behalf before they will be given access to PHI or allowed to take any action for a member. Proof of this authority may be one of the following forms:

- A power of attorney notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.



## **IU HUMAN RESOURCES**

400 East 7th Street, Poplars E165, Bloomington, IN 47405  
812-856-1234 | [hr.iu.edu](http://hr.iu.edu)

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