

# Health Savings Plan (HSP)

## **Combined Evidence of Coverage and Disclosure Form**

University of California

Carrier ID: UCOP

Effective Date: January 1, 2017

**This booklet constitutes a summary of the Prescription Benefits under the HSP Plan.**

Be sure you understand the Prescription Benefits offered under the HSP Plan before services are received.

**NOTICE**

Please read this Evidence of Coverage and Disclosure Form Booklet carefully to be sure you understand the Prescription Benefit, and its exclusions and general provisions. It is your responsibility to keep informed about any change in your health coverage.

Capitalized words have specific definitions. These can be found in the section describing the term in in the Definitions section.

**IMPORTANT**

No Member has the right to receive the Prescription Benefit of this Plan for Covered Services following the Member's termination of coverage under the HSP Plan in effect as of January 1, 2017 ("the Plan").

Benefits of the Plan are available only for covered Prescription Benefits during the term of the Plan is in effect and while the individual claiming Prescription Benefits is actually covered by the Plan.

Prescription Benefits may be modified during the term of the Plan as specifically provided under the terms of the Plan or upon renewal. If Prescription Benefits are modified, the revised Benefits (including any reduction in Prescription Benefits or the elimination of Prescription Benefits) apply for Services after the effective date of the modification. There is no vested right to receive the Prescription Benefits of the Plan.

Regents of the University of California is the Employer. OptumRx has been appointed as the Pharmacy Benefit Manager. OptumRx processes and reviews the prescription claims submitted under the Plan.

OptumRx provides prescription claims payment services only and does not assume any financial risk or obligation with respect to prescription claims.

**NOTE: The following Summary of Prescription Benefits describes the Prescription Benefits and applicable Coinsurances for your HSP Plan. The Summary of Prescription Benefits represents only a brief description of your Prescription Benefits. Please read the booklet carefully to learn about provisions, benefits and exclusions.**

## Summary of Prescription Benefits

**NOTE: See the end of this Summary of Prescription Benefits for important benefit footnotes.**

Covered Services	Member Coinsurance (after calendar year deductible is met)	
	UC Pharmacies & Participating Pharmacies	Non-Participating Pharmacies
Calendar Year Drug Deductible	Prescription drug coverage benefits are subject and accrue to the medical plan Deductible and Out of Pocket Maximum	
Calendar Year Drug Out-of-Pocket Maximum		
Prescription Drug Coverage <sup>1</sup>	UC Pharmacies & Participating Pharmacies	Non-Participating Pharmacies (Billed Charges)
Retail Pharmacy Prescriptions (up to a 30-day supply)		
• Contraceptive Drugs and Devices <sup>2</sup>	No Charge	Not Covered
• Formulary Generic Drugs	20% per prescription	40% per prescription
• Formulary Brand Name Drugs <sup>3,4</sup>	20% per prescription	40% per prescription
• Non-Formulary Brand Name Drugs <sup>3,4</sup>	20% per prescription	40% per prescription
UC Pharmacies and specific Retail Pharmacies (up to a 30-90 day supply)		
• Contraceptive Drugs and Devices <sup>2</sup>	\$0.00	Not Covered
• Formulary Generic Drugs	20% per prescription	Not Covered
• Formulary Brand Name Drugs <sup>3,4</sup>	20% per prescription	Not Covered
• Non-Formulary Brand Name Drugs <sup>3,4</sup>	20% per prescription	Not Covered
Home Delivery Program (up to a 90-day supply only through OptumRx Home Delivery Pharmacy)		
• Contraceptive Drugs and Devices <sup>2</sup>	\$0.00	Not Covered
• Formulary Generic Drugs	20% per prescription	Not Covered
• Formulary Brand Name Drugs <sup>3,4</sup>	20% per prescription	Not Covered
• Non-Formulary Brand Name Drugs <sup>3,4</sup>	20% per prescription	Not Covered
BriovaRx Specialty Pharmacy and Select UC Pharmacies (up to a 30-day supply) <sup>5,6,8</sup>	20% (Up to \$200 Coinsurance maximum)	Not Covered
Smoking Cessation Products		
• Over-the-Counter Drugs (requires prescription)	\$0.00	Not Covered
• Prescription Drugs	\$0.00	Not Covered
Diabetic Supplies (excluding syringes, needles, insulin and non-formulary test strips) <sup>7</sup>	\$0.00	Not Covered
Travel Vaccinations <sup>9</sup>		
• ACA preventative travel vaccinations (hepatitis A, hepatitis B, meningitis, polio)	No Charge (not subject to the calendar year deductible)	40% per prescription
• Other travel vaccinations (Japanese encephalitis, rabies, typhoid and yellow fever)	20% per prescription	40% per prescription

## Summary of Benefits

### Footnotes

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1. Amounts paid through the outpatient prescription benefit copayments accrue to the member's medical calendar year out-of-pocket maximum.
2. If a brand name contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without copayment.
3. Select formulary and non-formulary drugs require prior authorization by OptumRx to determine whether medically necessary, or when effective, lower cost alternatives are available.
4. If the member or physician requests a brand-name drug when a generic equivalent is available, the member is responsible for paying the difference between the cost for the brand-name drug and its generic equivalent, as well as the applicable generic copayment. The difference in cost that the member must pay is not applied to their calendar year out-of-pocket maximum.
5. Specialty drugs are specific drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers and other conditions that are difficult to treat with traditional therapies. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscular), by inhalation, orally or topically. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration and be obtained from BriovaRx<sup>®</sup> or select UC Pharmacies and may require prior authorization to determine medically necessary by OptumRx. Infused or Intravenous (IV) medications are not included as Specialty Drugs.
6. Specialty Drugs are covered only when dispensed through BriovaRx<sup>®</sup> and certain UC pharmacies unless Medical Necessary for a covered emergency.
7. Syringes, needles and insulin are covered at the applicable brand-name copayment and non-formulary test strips are covered at the applicable non-formulary copayment.
8. Specialty Drugs are limited to a quantity not to exceed a 30-day supply; however initial prescriptions for select specialty medications may be limited to a quantity not to exceed a 15-day supply through BriovaRx<sup>®</sup>. In such circumstances the applicable specialty drug will be pro-rated based upon the number of day supply.
9. Refer to your plan UC Health Savings Plan Benefit Booklet for more information on covered vaccinations and immunizations.

This Plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this Plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more any time after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

## Introduction to your HSP Plan

This HSP Plan is designed to reduce the cost of health care to you, the Member. In order to reduce your costs, much greater responsibility is placed on you.

### How the Plan Works

The following prescription drug benefit is separate from the health plan coverage. The Coordination of Benefits provision does not apply to this outpatient Prescription Benefit; however, the general provisions and exclusions of the Plan shall apply.

OptumRx's Drug Formulary is a list of preferred generic and brand medications that: (1) have been reviewed for safety, efficacy, and bio equivalency; (2) have been approved by the Food and Drug Administration (FDA); and (3) are eligible for coverage under the OptumRx Outpatient Prescription Benefit. Non-Formulary Drugs may be covered subject to higher Coinsurance amounts. Select Drugs and Drug dosages and most Specialty Drugs require prior authorization to determine whether Medically Necessary through the OptumRx process, including appropriateness of therapy and efficacy of lower cost alternatives. You and your Physician may request prior authorization from OptumRx.

Coverage for selected Drugs may be limited to a specific quantity as described in "Quantity Limits per Prescription or Refill".

If you have questions about your Prescription Benefits, please call OptumRx Member Services at 1-855-489-0651 or you can log on to [www.optumrx.com](http://www.optumrx.com) for additional information.

You should read your Prescription Benefit Booklet carefully. Your booklet tells you which prescription services are covered by your health plan and which are excluded. It also lists your Coinsurance and Out-of-Pocket responsibilities.

## **How to Obtain a Prescription at a Participating Pharmacy**

To obtain Drugs at a Participating Pharmacy, the Member must present his or her ID card.

Note: Except for covered emergencies, claims for Drugs obtained without using the Identification Card will be denied.

Benefits are provided for Specialty Drugs only when obtained through BrioRx and select UC Pharmacies, except in the case of an emergency. In the event of an emergency, covered Specialty Drugs that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary from a Non-Participating Pharmacy.

Special Note for contraceptive Drugs and devices: No Coinsurance will be assessed. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization to determine whether Medically Necessary to be covered without a Coinsurance.

If the Member or Physician requests a Brand Drug when a Generic Drug equivalent is available, the Member is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Drug and its Generic Drug equivalent, as well as the applicable Coinsurance. The difference in cost that the Member must pay is not applied to the Calendar Year Out-of-Pocket Maximum responsibility calculation.

The Member or prescribing provider may provide information supporting the medical necessity for using a Brand Drug versus an available Generic Drug equivalent through OptumRx prior authorization process. If the request is approved, the Member is responsible for paying the applicable Drug tier Co-payment.

In order to receive the highest level of Benefits, you should assure that your pharmacy is a participating pharmacy.

## **Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy**

To obtain prescription Drugs at a Non-Participating Pharmacy, the Member must first pay all charges for the prescription and submit a completed Direct Member Reimbursement Form for reimbursement. The Member will be reimbursed as shown on the Summary of Benefits based on the price actually paid for the Drugs. Claims must be received within 1 year from the date of service to be considered for payment.

## **Submitting a Claim Form**

In the event you pay out of pocket for a prescription, you can submit a Direct Member Reimbursement form after services have been received.

You will be reimbursed directly from OptumRx. Request for reimbursement must be submitted to OptumRx within 1 year after the prescription was filled. To obtain a Direct Member Reimbursement form, log on to [www.optumrx.com](http://www.optumrx.com). If you do not have the Internet, please call OptumRx Member Services at 1-855-489-0651 to have a form mailed to your home.

To submit a Direct Member Reimbursement form, send a copy of your itemized receipt as well as the completed Direct Member Reimbursement form to the address located on the form.

## **Outpatient Drug Formulary**

New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by a Pharmacy and Therapeutics Committee during scheduled meetings throughout the year. The Formulary includes most Generic Drugs. The fact that a Drug is listed on OptumRx Formulary does not guarantee that a Member's Physician will prescribe it for a particular medical condition.

A Member may call OptumRx Member Services at 1-855-469-0651 to inquire if a specific drug is included in the Formulary. Member Services can also provide Members with a printed copy of the Formulary. Members may also access the Formulary through the OptumRx Member Portal at [www.optumrx.com](http://www.optumrx.com).

## **Eligibility & Enrollment**

Information pertaining to enrollment can be found in the "Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members." A copy of this fact sheet is available in the HR Forms section of UCnet ([ucnet.universityofcalifornia.edu](http://ucnet.universityofcalifornia.edu)).

## OptumRx Member Portal

Your personal website is waiting. The OptumRx Member Portal offers a private, secure website designed just for you. All of your prescription benefit information is available and kept up-to-date in real time.

### Easy access allows you to:

- Manage all your prescriptions on a single dashboard
  - Update your information and complete health profile for home delivery
  - Order mail order refills
  - Compare prices at local pharmacies
  - Find your lowest prescription cost
  - Locate your pharmacy and get driving directions
  - Keep track of your health history
  - Learn more about your drugs
  - Take it all with you through the mobile app
  - Manage prescriptions for your dependents and family members, where appropriate
- ...and much more

Log on to [www.optumrx.com](http://www.optumrx.com). Use your member ID to register.

**Questions?** Call OptumRx Member Services at 1-855-469-0651. A representative is available to assist you 24 hours a day, 7 days a week.

## University of California (UC) Maintenance Drug Program

Members may obtain prescribed maintenance medications for up to a 3-month supply through OptumRx Home Delivery, select UC medical center pharmacies, or specified retail pharmacies. Location of available UC or specified retail pharmacies can be obtained by calling OptumRx Member Services at 1-855-469-0651. A representative is available to assist you 24 hours a day, 7 days a week.

## Obtaining Prescriptions through OptumRx Home Delivery

Using OptumRx Home Delivery is convenient and can save you time. If you take a consistent dose of a covered maintenance medication for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through home delivery. You can also obtain a 90-day supply for a covered maintenance medication through:

- Select UC Pharmacies
- Select OptumRx participating pharmacies such as Costco, Vons/Safeway and Walgreens

Call OptumRx Member Services at 1-855-489-0651 for additional information.



## Prior Authorization

A Prior Authorization (PA) may be required for certain medications. OptumRx and UC are committed to maximizing the value of your prescription drug benefit and lowering prescription costs. They work together with your doctor to ensure safe and effective use of select prescription medications.

Before your copay can be applied at the pharmacy, the medication must be preapproved by the Pharmacy Benefit Manager with the help of your doctor. You, your pharmacist or your doctor can start the prior authorization process.

Medicines that typically require a Prior Authorization (PA) are;

- Medications that have a higher possibility of overuse or may be prescribed outside of clinical dosing guidelines.
- Brand name medicines that have a generic available.
- High cost “specialty” medications, often used to treat uncommon conditions.
- Medicines with age limits.
- Covered medicines used for cosmetic reasons.
- Drugs not covered by the insurance company, but said to be medically necessary by the doctor. If a patient requires a particular medicine, the doctor must provide the insurance company with information indicating that there are not any other medicines that are effective and appropriate treatment for the patient.
- Drugs that are usually covered by the insurance company but are being used at a dose higher than “normal”.

A team of independent, licensed doctors, pharmacists and other medical experts review and discuss the latest medical guidelines and research to decide which drugs should be included in the Prior Authorization Program.

You can review your plan documents or your pharmacist will let you know when you pick up your prescription at the pharmacy if a Prior Authorization is needed. If you have questions, contact the Pharmacy Benefit Manager, OptumRx, at its website, [optumrx.com](http://optumrx.com).

OptumRx also offers a 24/7 call center with representatives to answer your questions. You can reach a representative by calling 1-855-489-0651. The mailing address and telephone number are:

OptumRx  
CA106-0286  
3515 Harbor Blvd.  
Costa Mesa, CA 92626  
1-855-489-0651

If you have a Prior Authorization that is denied and not approved, you will be responsible for the full cost of your prescription at the pharmacy. You may fill your prescription, but your copay will not apply.

## Quantity Limitations per Prescription or Refill

1. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. If a prescription Drug is packaged only in supplies exceeding 30 days, the applicable retail Coinsurance will be assessed. Some prescriptions are limited to a maximum allowed quantity based on Medical Necessity and appropriateness of therapy as determined by a Pharmacy and Therapeutics Committee.
2. Designated Specialty Drugs may be dispensed for a 15-day trial at a pro-rated Coinsurance for an initial prescription at BriovaRx, and with the Member's agreement. This Short Cycle Specialty Drug Program allows the Member to obtain a 15-day supply of their prescription to determine if they will tolerate the Specialty Drug before obtaining the complete 30-day supply, and therefore helps save the Member out-of-pocket expenses. BriovaRx will contact the Member to discuss the advantages of the Short Cycle Specialty Drug Program, which the Member can elect at that time. At any time, either the Member, or Provider on behalf of the Member, may choose a full 30-day supply for the first fill. If the Member has agreed to a 15-day trial, BriovaRx will also contact the Member before dispensing the remaining 15-day supply to confirm if the Member is tolerating the Specialty Drug. To find a list of Specialty Drugs in the Short Cycle Specialty Drug Program, the Member may visit [www.optumrx.com](http://www.optumrx.com) or call OptumRx Member Services at 1-855-469-0651, 24 hours a day, 7 days a week.
3. Drugs through the UC Maintenance Drug Program are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed, and refill authorizations cannot be combined to reach a 90-day supply.
4. Home Delivery Prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply.
5. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

## Claims and Appeals

### Grievances Regarding Benefits

#### (a) What is a Claim

A claim is a request for a benefit determination which is made in accordance with the Prescription Drug Plan's procedures. A claim may be submitted by you or your authorized representative. Submit claims to:

OptumRx  
1600 McConnor Parkway  
Schaumburg, IL 60173-6801  
1-855-489-0651

Please note that presentation of a Prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a Prescription to a Network Pharmacy, and the Network Pharmacy indicates your Prescription cannot be filled or requires an additional Co-Payment or Coinsurance, this is not considered an adverse claim decision. If you want the Prescription filled, you will have to pay either the full cost, or the additional Co-Payment or Coinsurance, for the Prescription Drug. If you believe you are entitled to some Plan benefits in connection with the Prescription Drug, submit a claim for reimbursement to the Pharmacy Benefit Manager under the procedures herein.

If you submit an incomplete claim form, incomplete receipts or an unsigned claim form, you will be advised within 30 days (and sooner if reasonably possible) of the information that is needed to complete the claim request.

### **(b) When Claims Should Be Filed**

After-purchase claims and claims for coordination of benefits should be filed with the Pharmacy Benefit Manager within 90 days of the date of purchase. Benefits are based on the Plan's provisions at the time the charges were incurred. The Pharmacy Benefit Manager reserves the right to deny claims that are filed after 365 days from the date of purchase unless you can demonstrate that it was not reasonably possible to submit the claim within the 90-day period.

These claims procedures address the period within which benefit determinations must be decided, not paid. Benefit payments must be made with reasonable periods of time following approval of the claim.

### **(c) Notification of Approval or Denial of an After-Purchase Claim**

You will be notified of the approval or denial of your after-purchase claim within 30 days of submission of a completed claim form. The Pharmacy Benefit Manager may take an additional 15 days additional time upon notice to you.

If the claim is denied, you will be notified of:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Prescription Drug Plan provisions on which the determination is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and
- A description of the Prescription Drug Plan's review procedures.

### **(d) Appeal Rights**

If you desire to appeal the Pharmacy Benefit Manager's denial of your prior authorization request, or denial of all or part of your after-purchase claim, you will have 180 days from the date you receive notice of this decision to file your appeal. You or your authorized representative may do so by submitting the appeal, along with Physician supporting documentation, if any, to the address and in the form described on the explanation of benefits denying all or a portion of your claim.

Certain criteria were relied upon by the Pharmacy Benefit Manager in determining whether to approve your request. You or your Physician may request a copy of the applicable criteria free of charge by sending a letter to OptumRx at the address below.

The Pharmacy Benefit Manager understands the importance of your involvement in decisions affecting your health care. The decision to continue with the requested medication is between you and your Physician. If you have additional questions regarding your Prescription Drug benefit, please contact the Pharmacy Benefit Manager's Customer Care Team.

You may contact OptumRx at its website, [optumrx.com](http://optumrx.com) or the OptumRx mobile app. OptumRx also offers a 24/7 call center with representatives to answer your questions. You can reach a representative by calling 1-855-489-0651

The mailing address and telephone number are:

OptumRx  
c/o Appeals Coordinator  
CA106-0286  
3515 Harbor Blvd.  
Costa Mesa, CA 92626  
1-855-489-0651

If your request involves urgent care, you, your authorized representative or your Physician may submit your appeal orally by calling the Pharmacy Benefit Manager's Customer Care Team at 1-855-489-0651.

The following is a summary of your appeal rights:

1. Your appeal must be submitted within 180 days from the date you receive a notice of adverse benefit determination that denies benefits for all or part of your claim or denies preauthorization (or, if additional information is being requested as described in the second paragraph below, then within 180 days following the last day on which you are permitted to submit the additional information before your request is denied).
2. You will be allowed an opportunity to submit written comments, documents or other information relating to your claim, and upon request and free of charge, afforded reasonable access to and copies of all documents and other information relevant to your claim.
3. Upon receipt of your appeal request, it will be reviewed in accordance with the claims procedures described herein.
  - a. Non-Urgent Care Request. If your request is not designated by your Physician as being for urgent care, in general, you must be notified of the determination on appeal not later than 30 days after receipt by the Plan of your request for review on appeal.
  - b. Urgent Care Request. If your request is designated as urgent care (as determined by your Physician), you must be notified of the determination not later than 72 hours after receipt of your request for review on appeal.

**(e) Appeals Procedures**

1. Applicable medical records, including client-specific applicable Plan language, will be forwarded to a reviewer in the clinical department of the Pharmacy Benefit Manager for each case review.
2. All documentation regarding any previous appeal, specific Prescription Drug Plan language, and any other relevant information the reviewer needs to properly evaluate each claim will also be forwarded. The reviewer will notify you of the appeals process, in

writing; inform you of the right to submit additional records for review; and provide the name and telephone number of a contact person to answer questions related to the appeal process.

3. The reviewer selected to conduct the review will review the documentation within a reasonable period of time, but no later than sixty (60) days after receiving the case.
4. Should additional information be needed, the reviewer may contact your Physician to request the additional information.
5. The reviewer will review available medical records and any additional information obtained from your Physician and will write a rationale in support of his/her final decision.
6. The final decision of the reviewer may affirm the Pharmacy Benefit Manager's determination in full (Deny Coverage), may reverse the Pharmacy Benefit Manager's determination in full (Approve Coverage), or may affirm the Pharmacy Benefit Manager's determination in part and reverse it in part (Modify Coverage).
7. A letter will be sent by the reviewer to you with a copy to the Pharmacy Benefit Manager, the patient (if someone other than you), and/or the attending Physician. The letter will include the final internal appeal decision, the reasons for the final decision, discussion, references to the Prescription Drug Plan provisions on which the decision is based, and a statement indicating that this is the final internal appeal decision. In addition to the letter, the Pharmacy Benefit Manager will receive a copy of the actual case review done by the reviewer.

#### **(f) Independent External Review Procedures**

You may request an independent external review of a final internal adverse benefit determination. The external review is subject to the following procedures and deadlines:

- You must submit a request for an external review within the four (4) month period after receipt of the notice of denial.
- A preliminary review determination will be made within five (5) business days following receipt of the external review request.
- You will be notified of the preliminary review determination within one (1) business day after completion of the preliminary review.
- In the event it is determined that the request for external review is incomplete, you will have the remainder of the four-month filing period to perfect the request or, if later, 48 hours following receipt of notice.
- The independent reviewer will notify you of acceptance for review, and deadline for submissions of additional information in a timely manner.
- The reviewer will be provided with documents and information considered in making its benefits determination within five (5) business days of assignment to the reviewer.
- You must submit additional information within ten (10) business days following receipt of notice from the reviewer.
- The reviewer shall forward to the Pharmacy Benefit Manager any additional information submitted by you within one (1) business day of receipt.
- In the event the Pharmacy Benefit Manager reverses its denial, it must provide notice to you and reviewer within one (1) business day of receipt.
- The reviewer must render a decision within 45 days of receipt of the request for review.

### **(g) Expedited External Review**

External review procedures may be expedited for cases where completion of an expedited internal appeal would seriously jeopardize the life or health of the patient or would jeopardize his or her ability to regain maximum function, a hospital or facility admission, availability of care, continued stay, or health care item or service for which he or she received Emergency Services, but has not been discharged from a facility. For an expedited review, the reviewer must provide notice of the final external review decision as expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after the reviewer receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that non-written notice, the reviewer will provide written confirmation of the decision.

### **(h) Your Right to Commence Arbitration**

Following a continued denial of your request for coverage after exhaustion of the mandatory appeals process described in this Benefits Booklet and, if filed timely, the external review, you can submit your claim to binding arbitration. Such submission must be filed within one year of the date of receipt of the final denial on the appeal under the Plan, and you must have complied with all time limits and other requirements specified herein. The request for binding arbitration must be filed in accordance with the JAMS arbitration rules that are in effect at the time of the commencement of the arbitration.

Any arbitration proceeding under the Plan shall be conducted in Oakland, California. The arbitrators may construe or interpret, but shall not vary or ignore the terms of the Plan, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. Any enforcement of the arbitrator's decision shall be brought in the Superior Court of Alameda County, California.

## **Individual and Family Deductibles**

There is a separate Deductible for services rendered by Preferred and Non-Preferred Providers. The Preferred Deductible must be met by charges by Preferred Providers only. The Non-Preferred Deductible is made up of charges by any combination of Preferred and Non-Preferred Providers.

The Deductibles must be made up of charges covered by the Plan and must be satisfied once during each Calendar Year. After the Calendar Year Deductible is satisfied for those Services to which it applies, Benefits will be provided for Covered Services without regard to any Deductible.

## **Member's Maximum Calendar Year Out-of-Pocket Responsibility**

1. Amounts paid through the outpatient prescription drug benefit Coinsurances do accrue to the member's medical calendar year out-of-pocket maximum. Amounts paid through the medical benefit do accrue to the member's prescription drug calendar year out-of-pocket maximum. Please refer to the Plan Contract for exact terms and conditions of coverage.
2. The per Individual and per Family maximum out-of-pocket responsibility each Calendar Year for Covered Services rendered by a non-participating pharmacy are shown on the Summary of Prescription Benefits.

UC Pharmacy and Participating out-of-pocket amounts and Non-Participating pharmacy Out-of-Pocket Maximum amounts do not cross accumulate.

Once a Member's maximum responsibility has been met\*, the Plan will pay 100% of the Allowable Amount for that Member's Covered Services for the remainder of that Calendar Year, except as described below. Once the Family maximum responsibility has been met\*, the Plan will pay 100% of the Allowable Amount for the Member's and all covered Dependents' Covered Services for the remainder of that Calendar Year, except as described below.

\*Note: Certain Benefits and amounts are not included in the calculation of the maximum Calendar Year out-of-pocket responsibility. These items are shown on the Summary of Prescription Benefits.

Charges for these items may cause a Member's payment responsibility to exceed the maximums.

## **OptumRx Member Services**

If you have questions about your Prescription Benefits or how to use this Plan, you may contact OptumRx Member Services at 1-855-469-0651. A representative is available to assist you 24 hours a day, 7 days a week.

The hearing impaired may contact OptumRx Member Services by dialing 771.

OptumRx Member Services can answer most questions over the telephone.

## **Exclusions**

No benefits are provided under the Outpatient Prescription Benefit for the following (please note, certain services excluded below may be covered under other benefits/portions of your HSP Evidence of Coverage – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. Any drug provided or administered while the Member is an Inpatient, or in a Physician's office, Skilled Nursing Facility, or Outpatient Facility;
2. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facility;
3. Drugs (except as specifically listed as covered under this Outpatient Prescription Drug Benefit), which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;

4. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
5. Drugs that are considered to be experimental or investigational;
6. Medical devices or supplies except as specifically listed as covered herein (see the Durable Medical Equipment Benefits, Orthotics Benefits, and Prosthetic Appliances Benefits sections of your Medical Plan Benefit Booklet). This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;
7. Blood or blood products (see the Hospital Benefits (Facility Covered Services) section of your Medical Plan Benefit Booklet);
8. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
9. Dietary or Nutritional Products (see the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefits sections of your Medical Plan Benefit Booklet);
10. Any drugs which are not self-administered. These medications may be covered under the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, and Family Planning Benefits sections of the HSP Evidence of Coverage Booklet;
11. All Drugs for the treatment of infertility;
12. Appetite suppressants or drugs for body weight reduction except when medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from OptumRx;
13. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) are ordered by a Physician, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered. Note: refer to your medical benefits for coverage of other contraceptive methods;
14. Compounded medications unless: (1) the compounded medication(s) includes at least one Drug, as defined, (2) there are no FDA-approved, commercially available medically appropriate alternative(s), (3) the Drug is self-administered, and (4) medical literature supports its use for requested diagnosis;
15. Replacement of lost, stolen or destroyed prescription Drugs;
16. For Members enrolled in a Hospice Program through an In-Network Hospice Agency, pharmaceuticals that are Medically Necessary for the palliation and management of terminal illness and related conditions are excluded from coverage under the Outpatient Prescription Drug Benefits, and are covered under Hospice Program Benefits (see Hospice Program Benefits under the Hospice Program Benefits section of the Medical Plan Benefit Booklet);
17. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection, medications prescribed to treat pain, or drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints;
18. Drugs obtained from a Pharmacy not licensed by the State Board of Pharmacy or included on a government exclusion list, except for a covered emergency;
19. Drugs packaged in convenience kits that include nonprescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs;
20. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).



## Definitions

Additional Definitions are included in your HSP Evidence of Coverage.

**Benefit** – a benefit provided to eligible Members under the plan consistent with any terms and conditions stated in the Plan.

**Brand Drugs** – Drugs which are FDA approved either (1) after a new drug application, or (2) after an abbreviated new drug application and which have the same brand name as that of the manufacturer with the original FDA approval. Brand Drugs are determined by OptumRx based on indicators set forth in the Medi-Span Prescription Pricing Guide.

**Calendar Year** – a period beginning on January 1 of any year and terminating on January 1 of the following year.

**Coinsurance** – the dollar amount or percentage of the allowable amount unless otherwise specified that a Member is required to pay for a specific Covered Services.

**Covered Services** – those medically necessary services and medications with a Benefit provided under the Plan.

**Drugs** – Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law

**Employee** – an individual who meets the eligibility requirements established by the Employer and communicated to OptumRx.

**Employer** – is The Regents of the University of California and its affiliate, Hastings College of the Law.

**Family** – the Member and all enrolled Dependents.

**Formulary** – a comprehensive list of Drugs maintained by a Pharmacy and Therapeutics Committee for use under the OptumRx Prescription Drug Program which is designed to assist Physicians in prescribing Drugs that are Medically Necessary.

**Generic Drugs** – Drugs that (1) are approved by the Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent or authorized generic to the Brand Drug, (2) contain the same active ingredient as the Brand Drug, and (3) typically cost less than the Brand Drug equivalent. Generic Drugs are determined by OptumRx based on indicators set forth in the Medi-Span Prescription Pricing Guide.

**Medically Necessary** - Services which are medically necessary include only those which have been established as safe and effective.

**Member/Individual** – The Employee, spouse, or Dependent covered by the Plan.

**Non-Formulary Drugs** – Drugs determined by a Pharmacy and Therapeutics Committee as products that do not have a clear advantage over formulary drug alternatives. Benefits are provided for Non-Formulary Drugs and are always subject to the Non-Formulary Coinsurance.

**Non-Participating Pharmacy** – a pharmacy which does not participate in the OptumRx Pharmacy Network.

**Out-of-Pocket Maximum** – the highest Coinsurance amount and individual or Family is required to pay for the designated prescription medications each year as indicated in the Summary of Benefits.

**Participating Pharmacy** – a pharmacy which participates in OptumRx's Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for OptumRx Members.

Note: OptumRx Home Delivery is a Participating Pharmacy.

**Plan** – the HSP Plan (Prescription Drug Plan) for eligible Employees and the Employer and their covered Dependents.

**Retiree** – an individual who meets the eligibility requirements established by the Employer and accepted by OptumRx.

**Specialty Drugs** — Drugs requiring coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy and are available at BriovaRx. Specialty Drugs may also require special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

**Specialty Pharmacy** – BriovaRx is the OptumRx Specialty Pharmacy to provide covered Specialty Drugs. Specialty Drugs may also be available at select UC medical center pharmacies.

For information on BriovaRx, please call OptumRx Member Services at 1-855-469-0651. You may also log on to [www.optumrx.com](http://www.optumrx.com).