## Prescription Drug Benefits for SAWS Members

Prescription drug benefits for SAWS employees are provided through CVS Caremark. The amount you pay per prescription is based on the category of prescription medication you receive. There are three prescription categories:

* **Generic** – Generic drugs are chemically equivalent to their brand name counterparts. Minor differences between generic and brand name drugs can include the shape, release mechanisms, packing, colors, flavors or preservatives of the medication. Unless your doctor specifies otherwise, you should check to see if a generic equivalent is available when a medication is prescribed. About 40% of all drugs dispensed in the United States today are generic drugs.
* **Preferred Brand Name** – These are brand name drugs identified as preferred due to their clinical value (safety and effectiveness) and affordability.
* **Non-Preferred Brand Name** – Non-preferred brand name drugs are brand name drugs that are not on the list of preferred brand name drugs. Please refer to your Commonly Prescribed Medications brochure

For short-term needs, you can have your prescription filled at any participating retail pharmacy. Simply show your Prescription ID card when you drop off your prescription. You will have to pay the copayment, based on the category of medication you receive.

**GENERICS**

Your benefit plan offers a lower copay/coinsurance\* when you choose a generic medication.

**Starting January 1, 2011 if you use certain brand-name drugs before trying a generic medication, your prescription may not be covered and you may need to pay the full cost**.\*\*

**Additionally, if either you or your doctor request a brand-name medicine when a generic alternative is available, you will pay the generic copay\*, plus the difference in cost between the brand-name and the generic medicine.**

**You can determine the coverage of specific medications through** [**www.caremark.com**](http://www.caremark.com) **or by calling the customer care number on the back of your card (877-636-0406).**

**Reasons to choose a generic:**

* Generic drugs are becoming the choice among doctors and patients—more than 65% of prescriptions filled today are for generic drugs, and that percentage is growing.1
* The U.S. Food and Drug Administration require that generic drugs meet the same quality standards as brand-name drugs.
* Brand-name drugs cost an average six times more than generic drugs1—yet generics are just as safe and effective.
* There are generic drugs available to treat most conditions, and your doctor can help you choose the right one for you.

**Your next steps:**

* Next time your doctor writes you a prescription, remember to ask for a generic.
* If you are currently taking a brand-name drug, ask your doctor to prescribe a generic medication before your next refill.
* Fill your prescription through a pharmacy in the CVS Caremark network (find one at [www.caremark.com](http://www.caremark.com)), as you generally will pay less than using a pharmacy outside the network.

To learn more about your specific savings when choosing a generic, visit the Savings Center at Caremark.com. You may also call us toll-free using the number on your Prescription Card.

**COPAYMENTS**

Your prescription drug copayments are as follows:

Retail Prescription Drugs (up to a 30-day supply)

• Generic Diabetic NO COST

• Other Generic $10.00

• Preferred Brand 30% ($25 min, $50 max)

• Non-Preferred Brand 45% ($40 min, $75 max)

• Specialty 4th tier $60.00

Mail Order Drugs (up to a 90-day supply)

• Generic Diabetic NO COST

• Other Generic $25.00

• Preferred Brand $62.50

• Non-Preferred Brand $100.00

• Specialty 4th tier $150.00

**MAIL ORDER**

If you have a chronic condition that requires ongoing medication, you should have your prescription filled through the mail order program. Through the mail order program, you can receive up to a 90 day supply of medication. Using mail service will allow you obtain a greater days supply while saving you money as opposed to obtaining the same days supply at your retail pharmacy. There are four ways to get started with mail service — choose the option that works best for you.

* **Internet:** Go to **www.caremark.com** and log in or register (if necessary). Click on **Start a New Prescription** and then click on **FastStart**. Fill in your Plan ID number, excluding the prefix letters (on your ID card), prescription name, doctor’s name and phone number, mailing address and payment information. A representative will contact your doctor to get your prescription information.
* **Phone:** You can call FastStart**®** toll-free at 1-800-875-0867, Monday through Friday,

7 a.m. to 7 p.m. CT. (For TDD assistance, please dial toll-free 1-800-231-4403.) A representative will ask for your Plan ID Number, prescription and doctor information, and then contact your doctor.

* **FastStart:** Have your doctor call the toll-free FastStart physician number, 1‑800‑378‑5697, and ask your doctor to call in the prescription for a 90-day supply with up to three refills.
* **Mail:** Complete the mail service order form, and mail in your written, 90-day prescription from your doctor. You can complete and print the form online at **Caremark.com** by clicking **New Prescriptions**.

**Your next steps**

* Contact your doctor’s office to request a new prescription for your medication therapy, if needed.
* Always be sure to get your prescription refilled before you run out of your medication.
* If you use mail service, sign up for our free automatic refill and prescription renewal services or refill reminders online at [www.caremark.com](http://www.caremark.com).

To learn more, visit Caremark.com or call us toll-free using the number on your Prescription Card.

**LIMITATIONS**

Coverage is not provided for the following prescription drug charges:

* Drugs for which a prescription is not required
* Drugs for which payment is unlawful where you reside
* Charges for which you are not legally required to pay
* Charges which would not have been made if you were not covered by the plan
* Experimental drugs or drugs labeled: “Caution – limited by federal law to investigational use”
* A prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician’s order
* Indications not approved by the Food and Drug Administration
* Immunization agents, biological sera, blood or blood plasma
* Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, excluding insulin
* Drugs used for cosmetic purposes
* Tretinoin for individuals over the age of 24. At the age of 25, member requires a Prior Authorization
* Medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
* Prescriptions which you are entitled to receive without charge from any workers’ compensation or similar law or any public program other than Medicaid
* Nutritional or dietary supplements, antiobesity drugs or anorexients
* Vitamins available without a prescription
* Fertility oral and injectable
* Contraceptive Implants (i.e. Norplant)
* IUDs
* Cervical Caps
* Diaphrams
* Flouride products

Paper Claims:

* If the need ever arises and you don’t have your ID card with you. Your plan allows you to pay for the prescription at the pharmacy and then submit your receipt along with a claim form to the following address (to obtain a claim form, please contact member services at the number provided on the back of your card):

CVS Caremark

P.O. Box 52136

Phoenix, AZ 85072

* Claims not submitted and received by CVS Caremark within twelve months after you receive services will not be considered for payment.

**Appeal Procedures**

San Antonio Water System (SAWS) has elected to delegate final claims and appeal authority for the pharmacy benefits provided by CVS Caremark under its health plan to CVS Caremark. Therefore, CVS Caremark, acting on behalf of SAWS, will provide the following claims and appeals review services:

* Pre-authorization Claim Review Services;
* Pre-Service Appeals Review Services; and
* Post-Service Appeals Review Services.

**Definitions**

The following terms are used herein to describe the claims and appeals review services provided by CVS Caremark:

**Adverse Benefit Determination** – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a pharmacy benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a pharmacy benefit based on the application of a utilization review or on a determination of a plan member’s eligibility to participate in the Plan. An adverse benefit determination also includes a failure to cover a pharmacy benefit because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate.

**Claim** – A request for a pharmacy benefit that is made in accordance with the Plan’s established procedures for filing benefit claims.

**Medically Necessary (Medical Necessity)** – Medications, health care services or products are considered Medically Necessary if:

* Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
* Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
* Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
* Use of medication, service or product is not solely for the convenience of the member, member’s family, or provider.

**Post-Service Claim** – A Claim for a pharmacy benefit that is not a Pre-Service Claim.

**Pre-authorization** – CVS Caremark’s pre-service review of a member’s initial request for a particular medication. CVS Caremark will apply a set of pre-defined criteria (provided by SAWS) to determine whether there is need for the requested medication.

**Pre-Service Claim** – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the pharmacy benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include member requests for pre-authorization.

**Urgent Care Claim** – A Claim for a medication, service, or product where a delay in processing the Claim: (i) could seriously jeopardize the life or health of the member, and/or could result in the member’s failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member’s condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product.

**Claims and Appeals Process**

**Pre-authorization Review:**

CVS Caremark will implement the prescription drug cost containment programs requested by the Plan Sponsor by comparing member requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS Caremark determines that the member’s request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

**Appeals of Adverse Benefit Determinations:**

If an Adverse Benefit Determination is rendered on the member’s Claim, the member may file an appeal of that determination. The member’s appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after the member receives notice of the Adverse Benefit Determination.

If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, the member and/or the member’s attending physician may submit an appeal by calling CVS Caremark.

The member’s appeal should include the following information:

* Name of the person the appeal is being filed for;
* CVS Caremark Identification Number;
* Date of birth;
* Written statement of the issue(s) being appealed;
* Drug name(s) being requested; and
* Written comments, documents, records or other information relating to the Claim.

The member’s appeal and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark

Appeals Department

MC109

P.O. Box 52084

Phoenix, AZ 85072-2084

Fax Number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician-only toll-free number: 1-866-443-1183

**CVS Caremark’s Review:**

The review a member’s Claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirements of PPACA and any related laws. Members will be accorded all rights granted to them under PPACA and any related laws.

CVS Caremark will provide the first-level review of appeals of Pre-Service Claims. If the member appeals CVS Caremark’s decision, the member can request an additional second-level Medical Necessity review. That review will be conducted by an Independent Review Organization (“IRO”).

**Timing of Review:**

***Pre-Authorization Review*** – CVS Caremark will make a decision on a Pre-Authorization request for a pharmacy benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 72 hours (and within 24 hours, effective January 1, 2012).

***Pre-Service Claim Appeal*** – CVS Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives the member’s appeal. If CVS Caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, the member may appeal that decision by providing the information described above. A decision on the member’s second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If the member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).

**Post-Service Claim Appeal** – CVS Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 60 days after it receives the appeal.

**Scope of Review:**

During its pre-authorization review, first-level review of the appeal of a Pre-Service Claim, or review of a Post-Service Claim, CVS Caremark shall:

* Take into account all comments, documents, records and other information submitted by the member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
* Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
* Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly-situated members; and
* Provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If a member appeals CVS Caremark’s denial of a Pre-Service Claim, and requests an additional second-level Medical Necessity review by an IRO, the IRO shall:

* Consult with an appropriate health care professionals who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
* Identify the health care professional, if any, whose advice was obtained on behalf of the plan in connection with the Adverse Benefit Determination; and
* Provide for an expedited review process for Urgent Care Claims.

**Notice of Adverse Benefit Determination:**

Following the review of a member’s Claim, CVS Caremark will notify the member of any Adverse Benefit Determination in writing. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

* The specific reason or reasons for the Adverse Benefit Determination;
* Reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
* A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
* If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
* If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO’s explanation of the scientific or clinical judgment for the IRO’s determination, applying the terms of the Plan to the member’s medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

**Authority as Claims Fiduciary:**

CVS Caremark shall serve as the claims fiduciary with respect to pre-authorization review of prescription drug benefit Claims arising under the Plan, first-level review of appeals of Pre-Services Claims, and review of Post-Service Claims. CVS Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties.

CVS Caremark is not responsible for the conduct of any second-level Medical Necessity review performed by an IRO

**HIPAA Privacy and Security**

This document applies to the following group health plans sponsored by the San Antonio Water System: SAWS HMO Medical Plan; SAWS POS Medical Plan; SAWS PPO Medical Plan; SAWS Dental Plan; SAWS Vision Plan; SAWS Medical Reimbursement Account, SAWS Pharmacy Benefit Plan; SAWS Employee Assistance Program. These are each referred to in this document as the “Plan.”

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") protects the privacy of certain types of individual health information, regulates the use of such information by the Plan and imposes certain security protection measures concerning electronic health information. The Department of Health and Human Services has issued regulations on this subject that can be found at 45 CFR Parts 160 and 164 ("HIPAA Regulations"). The individual health information that is protected ("Protected Health Information" or "PHI") is any information created or received by the Plan that relates to:

* your past, present or future physical or mental health or your past, present or future physical or mental condition;
* the provision of health care to you; or
* the past, present, or future payment for health care.

However, HIPAA allows medical information, including PHI, to be disclosed by the Plan to the Plan Sponsor and to be used by the Plan Sponsor (San Antonio Water System). The permitted disclosures to and uses by the Plan Sponsor of medical information are as follows:

* The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of (1) obtaining premium bids for providing insurance coverage; or (2) modifying, amending, or terminating the Plan (“Summary Information”). The Plan Sponsor may use Summary Information so received from the Plan only for these two listed purposes.
* The Plan may disclose to the Plan Sponsor, and the Plan Sponsor may use, information on whether an individual is participating in the Plan or is enrolling or disenrolling in the Plan.
* The Plan may disclose PHI to the Plan Sponsor and/or the Plan Sponsor may use such PHI if you have specifically authorized in writing such disclosure and/or use.
* The Plan may disclose PHI to the Plan Sponsor, and the Plan Sponsor may use and/or disclose PHI, to carry out plan administration functions, such as activities relating to:
  + obtaining premiums or to determining or fulfilling responsibility for coverage and provision of benefits under the Plan;
  + payment for or obtaining or providing reimbursement for health care services. Payments under this Plan generally are made either to the health care provider or to the SAWS employee or retiree participating the Plan. All Plan Participants are hereby notified and should be aware that the Plan and the Plan Sponsor will be providing PHI concerning all dependents of a SAWS employee or retiree to the employee or retiree as part of the Explanation of Benefits and when payments are made directly to the employee or retiree for reimbursement for covered services under the Plan. If there is a legitimate reason why a dependent (spouse or child) of a SAWS employee or retiree does not want the SAWS employee or retiree to receive PHI, the dependent should so inform his or her health care provider and should also contact the Human Resources Department at SAWS.
  + determining eligibility for the Plan or eligibility for one or more types of coverage or benefits provided under the Plan
  + coordination of benefits or determinations of copayments or other cost sharing mechanisms;
  + adjudication and subrogation of claims, billing, claims management, collection activities and related health care data processing;
  + payment under a contract for reinsurance;
  + review of health care services with respect to medical necessity, coverage under the health plan, appropriateness of care, or justification of charges;
  + utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services;
  + disclosure to consumer reporting agencies of any of the following PHI regarding collection of premiums or reimbursement: name and address, date of birth, Social Security Number, payment history, account number and name and address of the health plan.
  + medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
  + business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Plan, including formulary development and administration and/or the development or improvement of methods of payment;
  + resolution of internal grievances;
  + prosecution or defense of administrative claims or lawsuits involving the Plan or Plan Sponsor;
  + conducting quality assurance and improvement activities, case management and care coordination;
  + evaluating health care provider performance or Plan performance;
  + securing or placing a contract for reinsurance of risk relating to health care claims, other activities relating to the renewal or replacement of stop-loss or excess of loss insurance;
  + contacting health care providers and patients with information about treatment alternatives.

These uses and disclosures are consistent with the HIPAA Regulations.

The Plan Sponsor has agreed to (and the Plan has received a certification from the Plan Sponsor evidencing such agreement) the following restrictions:

1. The Plan Sponsor will not use or further disclose the PHI except (1) as described above or (2) as otherwise required by law.

2. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides PHI (such as the third-party administrator of the Plan) will agree to the same restrictions and conditions on the use and disclosure of PHI that apply to the Plan Sponsor. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides electronic PHI must agree to implement reasonable and appropriate security measures to protect the information.

3. The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

4. The Plan Sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the Plan Sponsor becomes aware. The Plan Sponsor will report to the Plan any security incident of which the Plan Sponsor becomes aware.

5. The Plan Sponsor will give you access and provide copies to you of your PHI in accordance with the HIPAA Regulations.

6. The Plan Sponsor will allow you to amend your PHI in accordance with the HIPAA Regulations.

7. The Plan Sponsor will make available PHI to you in order to make an accounting of PHI in accordance with the HIPAA Regulations.

8. The Plan Sponsor will make available its internal practices, books and records relating to the use and disclosure of PHI received from the Plan to the Secretary of Health and Human Services (or the Secretary's designee) for determining compliance by the Plan with the HIPAA Regulations.

9. The Plan Sponsor will, if feasible, return or destroy all protected PHI received from the Plan and retain no copies of the PHI when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The Plan Sponsor will ensure that adequate separation between the Plan and Plan Sponsor is established. Only the following employees or classes of employees or other persons under the control of the Plan Sponsor will be given access to the PHI to be disclosed:

Human Resources personnel

The Plan Sponsor will ensure that this adequate separation is supported by reasonable and appropriate security measures to the extent that these individuals have access to electronic PHI.

11. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan, except enrollment/disenrollment information and Summary Information, which are not subject to these restrictions.

Human Resources personnel shall separate and segregate PHI from the regular employment files of employees. The access to and use of PHI by Human Resources personnel is limited to the plan administration functions that the Plan Sponsor performs for the Plan. SAWS employees who violate this section are subject to disciplinary action by the SAWS, including, but not limited to, reprimands and termination.

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