

**PRESCRIPTION**

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**DRUG**

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**PROGRAM**

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**TEMPLE**  
**UNIVERSITY**

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## **How to Use This Booklet**

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This booklet contains pertinent information about your prescription drug program, including covered and non-covered services, co-payment and deductible amounts and program limitations.

The “Definition of Terms” section is a resource designed to help you better understand the terminology used to describe specific elements of your coverage.

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## **Introduction**

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This booklet has been prepared so that you may become acquainted with your benefits under the Temple University Prescription Drug Program (the “Program”), which is available to active eligible employees. Benefits under the Program are paid by Temple University from its general assets and are administered by CVS Caremark, under the terms of an administrative services agreement.

Benefits will not be available to a greater extent than is Medically Appropriate. The amount of benefits for any prescription drugs covered under the Program will not be greater than the amount charged by the Pharmacy and will not be more than any maximum amount or limit described or referred to in this booklet.

### **Important Notices:**

#### **Regarding Experimental or Investigative Drugs:**

The Program does not cover Drugs that are Experimental or Investigative in nature because those Drugs are not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, situations may exist when a Participant and his or her Physician agree to utilize Experimental or Investigative Drugs. If a Participant is prescribed and dispensed Experimental or Investigative Drugs, the Participant will be responsible for the cost of the Drugs. A Participant or his or her Physician may contact CVS Caremark to determine whether a Drug is considered an Experimental or Investigative Drug. The term “Experimental or Investigative Drug” is defined in the Definitions section of this booklet.

#### **Regarding Drugs Used for Cosmetic Purposes:**

The Program does not cover Drugs which are prescribed for Cosmetic Purposes because they are not required as part of the Medically Appropriate treatment of an illness, injury or congenital birth defect. Situations may exist when a Participant and his or her Physician decide to pursue a course utilizing Drugs for Cosmetic Purposes. In such cases, the Participant is responsible for the cost of the Drugs. A Participant or his or her Physician may contact CVS Caremark to determine whether a Drug is considered prescribed for Cosmetic Purposes.

The term “Drugs used for Cosmetic Purposes” is defined in the Definitions section of this booklet.

#### **Regarding Prior Authorization:**

The Program requires prior authorization for benefits to be paid for certain Drugs. These requirements help to ensure that Participants are receiving the appropriate medication for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration.

If you try to purchase Drugs on the Prior Authorization List (available from CVS Caremark), you will be advised at the Pharmacy that verification of a diagnosis for the condition being treated will be necessary. To obtain verification, your treating physician should contact the Plan through CVS Caremark.

If the request for coverage is approved, the approval for that specific Drug will be for a period from several days up to a maximum of one year.

If the request is denied, you will receive notice from CVS Caremark explaining the reasons for the denial. If you are not satisfied with CVS Caremark’s decision, you have the right to appeal the decision.

Situations may exist when a Participant and his or her physician decide to utilize Drugs without first obtaining prior authorization. In such cases, the Participant is responsible for the cost of the Drugs.

### **Regarding Drugs Dispensed in Excess of Quantity Limits:**

There are certain Drugs that are subject to quantity limits, as determined by federal/state regulations and/or manufacturer's recommendations that restrict the quantity per dispensing and/or the number of refills for a certain medication. A Participant or his or her Physician may contact CVS Caremark to determine whether a particular Drug is subject to a quantity limit. The Plan does not cover the cost of Drugs which are dispensed in excess of an applicable quantity limit.

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## **General Information**

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### **Eligibility**

You are eligible to enroll for coverage under the Prescription Drug Program if you are an eligible employee of Temple University who is described in the Employment Group in Appendix A to this booklet. Appendix A also describes the Co-payment requirements for your Employment Group. Students and individuals classified by the University as part-time, seasonal or temporary employees are not eligible to participate.

An eligible employee will not be covered unless he or she enrolls for coverage. Enrollment includes your agreement to pay for your share of the cost of coverage on a before tax basis.

Some Employment Groups are subject to an eligibility service requirement. Contact the University's Benefits Office to determine the earliest effective date for your coverage (provided you timely enroll).

### **Dependents Eligible for Enrollment**

Your spouse and your children under 26 years of age (including biological children, foster children, stepchildren, children legally placed for adoption and your and your spouse's legally adopted children) are eligible for enrollment.

Upon application to and acceptance by the Program, you may continue coverage for dependent children 26 years of age or older who are incapable of self-support due to a physical or mental handicap which occurred prior to age 26, and who were enrolled for coverage as dependents prior to age 26.

Each person included under your coverage is entitled, separately, to the benefits described in this booklet, except where noted otherwise.

### **Newborn Dependent Provision**

Benefits are available for a newborn child of a Participant for 31 days immediately following birth. To continue coverage beyond this period, application must be made by the Participant within 31 days after the birth, and your appropriate share of the cost for such coverage must be paid when billed.

### **Changes in Your Address or Family Status**

It is important that you notify Temple University promptly of any change in your address or your family status, including marriage, divorce, birth or adoption of a child, marriage of dependent children, death of spouse or child.

### **How Benefits Are Received**

The administrator of the prescription drug benefit is CVS Caremark. The CVS Caremark network of participating Network Pharmacies is nationwide with over 64,000 participating pharmacies.

When you present your Prescription Drug Plan Identification Card to a participating Network Pharmacy, your cost for a prescription or a refill will be the co-payment as indicated in Appendix A for your Employment Group.

Maintenance Drugs are drugs prescribed to treat conditions of a long-term or chronic nature. If your Physician prescribes a Maintenance Drug for 3 months or more, you have the option of filling the prescription through a CVS Caremark Mail Order Pharmacy. Using a Mail Order Pharmacy for Maintenance Drugs will save you trips to the pharmacy and prescription co-payment expenses.

## **Release of Information**

Any person or entity having information relating to an illness or injury for which benefits are claimed under the Program by you or your enrolled dependent may furnish to CVS Caremark, upon its request, any information (including copies of records relating to the illness or injury).

In addition, CVS Caremark may furnish similar information to other entities providing similar benefits at your request.

CVS Caremark shall provide to Temple University upon request certain information regarding claims and charges submitted to CVS Caremark. This information will be adjusted to prevent the disclosure of the identity of Participants and will otherwise conform to the privacy requirements of the Health Insurance Portability and Accountability Act ("HIPAA").

## **Coordination of Benefits**

The Program's Coordination of Benefits rules are applicable only when you, your spouse or your dependent(s) are eligible for benefits under more than one group health plan.

When you receive health care services that are also covered under another plan or program, a determination is made as to which plan is "primary" and which plan is "secondary." The primary plan considers the services without regard to the secondary plan. The secondary plan will then consider the balances on covered services according to the limitations of its program.

If this Program is determined to be the secondary plan, the Program will not pay more than it would have had there been no other coverage.

The primary plan will be determined in the following order:

1. If the other plan does not include a provision to coordinate benefits, it will be the primary plan.
2. If the other plan includes a provision to coordinate benefits then:
  - A. The plan covering the patient as the employee is the primary plan.
  - B. Except for situations where the parents of a child are separated or divorced, the plan of the parent whose date of birth (month, day) falls earlier in the calendar year is the primary plan for that child. If both parents have the same birth date, the plan which covered the parent longer shall be primary.

In the event this Program is coordinating with a plan that uses a rule based on the gender of the parent, the plan of the male parent is primary (except for situations where the parents of a child are separated or divorced).

- C. In those situations where the parents are separated or divorced, the primary plan is determined as follows:
  - 1) The plan covering the parent with custody of the child is primary.
  - 2) If the parent with custody of the child has remarried, the stepparent's plan will pay for covered services before the plan of the parent without custody.

- 3) A court decree may determine the primary plan. You should advise your employer of any court decree.
- D. When the determination cannot be made with the above rules, then the plan that has covered the patient for the longer period of time will be the primary plan, except:
  - ...the plan which covers the patient as an active employee (or a dependent of such a person) is the primary plan over a plan that covers a patient as a laid-off or retired person (or a dependent of such a person).
  - ...if either plan does not have this condition then it does not apply and the plan which has been in effect the longer period of time is primary.
3. If services are provided under a governmental program for which the Participant pays a periodic rate, that program is the primary plan, except when prohibited by law or when the Participant elects Medicare as secondary coverage.

This Program may pay its benefits first and determine liability later. If it is determined that this Program is the secondary plan, the Program has the right to recover the expense already paid in excess of its liability as the secondary plan. If the other health care plan is the primary plan, CVS Caremark may limit payment so that the Program will not pay more than the difference, if any, between the primary plan's payment and the charge. Benefits payable under another plan include benefits that would have been payable had the claim been duly made. When this Program is determined to be primary, but payment was made by another plan, this Program has the right to reimburse the other plan the amount which the Benefit Administrator determines is the Program's liability.

The Benefit Administrator may release to or obtain from any person or organization any information about coverage, expenses and benefits which may be necessary to coordinate benefits. The employee on his/her own behalf and on behalf of his or her dependent(s) may be required to furnish information and to take such other action as is necessary to implement the coordination of benefits rules of this Program.

## **Termination of Coverage**

When your employment with Temple University ends, or your eligibility for coverage otherwise terminates because you are no longer a member of an eligible group, benefits under this Program will terminate for all claims incurred after your termination date, unless you elect COBRA continuation coverage as described below.

Temple University may retroactively terminate your coverage if you engage in fraud or make an intentional misrepresentation of material fact. Rescissions of coverage will be effective as of the date of the fraud or material misrepresentation. You will receive at least 30 days advance written notice in the event of rescission of your coverage.

## **Plan Modification and Amendment**

Temple University reserves the right to modify or amend the Program and the benefits described hereunder at any time. Any such amendment will be determined solely by Temple University and may apply to some or all Employment Groups. Although Temple University expects to continue to maintain the Program indefinitely, the benefits under the Program are not vested and the University may modify, amend or terminate the Plan from time to time in its sole discretion. Any amendments which affect Program Participants will be communicated to them within the time period required by law. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements between the University and the bargaining representatives of any employees.

## **Plan Termination**

Temple University reserves the right to terminate, suspend or withdraw the Program at any time. Any such termination of benefits will be determined solely by Temple University and may apply to the Program as a whole, or

to one or more Employment Groups. Upon termination, the rights of participants are limited to claims incurred and due up to the date of termination. Any termination of the Program will be communicated to Participants within the time period required by law. In the event of Program termination, all claims incurred by a Participant must be received by the Benefit Administrator within 90 days after the date of termination.

### **Interpretation of the Program**

Temple University and, in its capacity as professional services provider, the Benefit Administrator, have the sole and absolute discretion to interpret and construe the provisions and terms of the Program, to resolve any disputes which may arise under the Plan and otherwise to determine the operation and administration of the Program. Any and all such decisions and determinations made under the Program shall be final and binding upon the affected parties.

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## Prescription Drug Program

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### Prescription Drug Benefits

Benefits will be provided for Covered Drugs for out-of-hospital use (but not while a patient is in a nursing home or other institution) dispensed by a legally licensed Pharmacy on and after the effective date of your enrollment in the Plan. This benefit includes Prescription Orders which the Pharmacy receives by phone from your doctor.

Benefits are available for up to a 34-day supply of a Covered Drug except for Maintenance Drugs, for which benefits may be provided for up to a 100 units. "Maintenance drugs" are recognized by CVS Caremark for the treatment of chronic or long term conditions such as, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis.

### Covered Drugs

Covered drugs are those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without prescription," or which require a prescription by state law. Insulin is also a covered drug, but not diabetes supplies such as syringes, testing strips, lancets and glucometers.

Injectible drugs and infertility drugs are covered. Drugs prescribed and used as a contraceptive are covered.

Covered drugs do not include those described under "Prescription Drug Exclusions," below.

This Prescription Drug Program is administered by CVS Caremark and benefit payments are based on whether or not the pharmacy is a CVS Caremark Network Pharmacy.

### How Retail Pharmacy Benefits Are Received

When you purchase Covered Drugs from a CVS Caremark Network Pharmacy, you should present your prescription order and Prescription Drug Program Identification Card to the Pharmacist. The Pharmacist will use a computerized system to confirm your eligibility for benefits and determine the cost of your prescription, including the share of the cost you will be asked to pay. The Network Pharmacy will bill the Program. You will not have to file a claim form.

When a Non-Network Pharmacy dispenses Covered Drugs, it will be necessary for you to pay the Pharmacy's regular charge for the prescription. Then you must complete and sign a claim form, including all the specified drug and patient information. Send it along with your paid receipt to CVS Caremark at the address indicated on the claim form.

If your doctor has prescribed medication that you will need to take regularly over a long period of time, your doctor has the option of prescribing a drug supply that will last up to 90 days when purchased through the Mail Order Program.

### How Mail Order Prescriptions Are Received

When your doctor prescribes chronic or "maintenance" drug therapies, ask him to prescribe a 90 day supply, plus refills. Enclose your original prescription (no photocopies) with your mail service order form and send to CVS Caremark. Follow the directions on the mail order form. Make certain that you include appropriate payment Mail order also can be initiated on Caremark's Web site, [www.caremark.com](http://www.caremark.com), or by contacting Caremark's FastStart at 1-800-378-5697.

## Timely Filing of Claims

Claims for reimbursement for Covered Drugs purchased by a Participant from a Pharmacy must be received by Caremark, along with any supporting documentation required by Caremark, no later than one (1) year after the date the Covered Drugs were purchased.

## Co-payment

See Appendix A with respect to your Employment Group for the applicable Co-payment. The Co-payment is the portion of the Allowable Charge of a Covered Drug that you are required to pay. Costs in excess of the Allowable Charge are your responsibility.

## Prescription Drug Exclusions

Except as specifically provided in this booklet, no benefits shall be provided for the following:

- Drugs dispensed without a Prescription Drug Order;
- Drugs which by law may be dispensed without a Prescription Drug Order (*e.g.*, over-the-counter medications) even though a Prescription Drug Order may be written for the Drug;
- Drugs obtained through mail order prescription drug services of a Non-Member Mail Order Pharmacy,
- Devices of any type, even though such devices may require a Prescription Drug Order including, but not limited to, ostomy supplies, therapeutic devices, artificial appliances hypodermic needles, syringes, vials or similar devices, including devices used for the treatment or maintenance of diabetic conditions, such as diabetes testing strips, lancets, and glucometers;
- Drugs dispensed to you while you are a patient in a facility including, but not limited to, a hospital, skilled nursing facility, institution, Health Care Practitioner's office or free-standing facility;
- Drugs which are not Medically Appropriate as determined by Caremark (see Important Notice in the Introductory section of this booklet);
- Drugs used for Cosmetic purposes and not part of the Medically Appropriate treatment of an illness, injury or congenital birth defect (see Important Notice in the Introductory section of this booklet);
- Drugs which are Experimental or Investigative in nature (see Important Notice in the Introductory section of this booklet);
- Drugs subject to prior authorization for which such authorization is not obtained (see Important Notice in the Introductory section of this booklet);
- Drugs dispensed in excess of quantity limits or lifetime supply limits unless an exception has been granted;
- Drugs which are not prescribed by an appropriately licensed Health Care Practitioner;
- Drugs prescribed for persons other than you or your eligible dependents;
- Drugs for any loss sustained or expenses incurred as a member of the armed forces of any nation while on active duty; or losses sustained or expenses incurred as a result of enemy action or act of war, whether declared or undeclared; drugs for which benefits are provided by the Veteran's Administration or by the Department of Defense for the members of the armed forces of any nation while on active duty;
- Drugs for any occupational illness or bodily injury arising out of, or in the course of, employment for which you have a valid and collectible benefit under any Worker's Compensation Law, United States Longshoreman's Act or Harbor Worker's Compensation Act, Occupational Disease Act or Law, whether or not you claim the benefits or compensation;
- Drugs for injuries resulting from the maintenance or use of a motor vehicle if such drugs are paid under a plan or policy of motor vehicle insurance including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- Drugs for which you would have no obligation to pay;
- Drugs furnished without charge to you;
- Drugs which may be paid under your group medical coverage with Temple University;
- Drugs prescribed or requested after the date of termination of your coverage under this Program, except as otherwise provided under the COBRA continuation coverage provisions of this booklet;
- Appetite suppressants;

- Dietary Supplements, amino acid supplements and health foods and prescription vitamins except for pre-natal and pediatric vitamins;
- Smoking deterrent agents including smoking cessation drugs;
- Drugs used for athletic performance enhancement;
- Injectibles used for the treatment of infertility when they are prescribed solely to enhance or facilitate conception;
- The administration or injection of Drugs;
- Blood and blood products;
- Unauthorized refills;
- Medications for weight reduction;
- Intravenous drugs and intravenous solutions administered by home infusion companies; and
- Drugs for a use not approved by the U.S. Food and Drug Administration.

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## COBRA Continuation Coverage

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Federal law requires that most group health plans, including this Prescription Drug Program, give employees and their families the opportunity to continue their health care coverage at their own expense when there is a “qualifying event” that would otherwise result in a loss of coverage. Those individuals who are entitled to continue coverage are referred to as “qualified beneficiaries.” Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the group health plan, a covered employee’s spouse, and dependent children of the covered employee. The rules apply to former as well as active employees and our Program extends certain continuation rights to domestic partners as well as spouses.

Continuation coverage under the Program is the same coverage that the Program gives to participants or beneficiaries under the Program who are not receiving continuation coverage. If you are a qualified beneficiary, you may elect continuation coverage under the Program if you were covered immediately before the qualifying event. If you elect such continuation coverage, you will have the same rights under that Program as other covered participants or beneficiaries who are not receiving continuation coverage. These rights include the right to change coverage under the Program during open enrollment and in certain other occasions during the year.

### **How long will my continuation coverage last?**

You will be permitted to elect to continue coverage under COBRA only if you would otherwise lose coverage because of a “qualifying event.” A loss of coverage occurs if benefits are no longer available under the same terms and conditions as a result of the event.

Whether an event is a qualifying event depends on whether you are covered under a plan as an employee, spouse, or a dependent child. The maximum period that COBRA coverage will last depends on the qualifying event that applies.

The following chart shows the qualifying events and the maximum period (in months) for continuing coverage.

Person \ Event	Termination of employment or relationship with the University (for reasons other than gross misconduct)	Reduction of employee’s hours	Divorce or legal separation of employee from spouse	Death of employee	Entitlement of employee to Medicare	Child’s loss of dependent status under plan
Employee	18	18	N/A	N/A	N/A	N/A
Spouse	18	18	36	36	36	N/A
Dependent Child	18	18	36	36	36	36

Please keep in mind that an event must result in a loss of coverage to be a qualifying event.

A qualified beneficiary’s continuation coverage will be terminated before the end of the maximum period if any required premium is not paid in full on time; if the qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary; if Temple University stops providing the Program for its

employees; or, if coverage is being continued because of the special extended coverage period for disabled individuals (see, below) and it is determined that the person is no longer disabled under the Social Security laws. Continuation coverage may also be terminated for any generally applicable reason the Program would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

### **How can I extend the length of continuation coverage?**

If your qualifying event would ordinarily result in a maximum continuation coverage period of 18 months, an extension of the period may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Benefits Office of a disability or a second qualifying event in writing within 60 days of that event in order to extend the period of continuation coverage. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage. All notices for an extension should be furnished to the Benefits Office at the address set forth at the end of this notice.

***Disability.*** An 11-month extension of coverage may be available if any of the qualified beneficiaries in your family is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must furnish the Benefits Office with a copy of the disability determination within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. If the disability determination was made before the date of the qualifying event (and no subsequent determination has been made that the individual is no longer disabled), you must notify the Benefits Office of the disability within 60 days of the loss of coverage. All of the qualified beneficiaries in your family unit who have elected continuation coverage based on the same qualifying event will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Benefits Office of that fact within 30 days of the SSA's determination.

***Second Qualifying Event.*** An 18-month extension of coverage may be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Program. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Program if the first qualifying event had not occurred. You must notify the Benefits Office in writing within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

***Medicare Entitlement Followed by Qualifying Event.*** If a qualifying event occurs less than 18 months after the date you become entitled to Medicare, the period of continuation coverage for your qualified beneficiaries is 36 months from the date of your Medicare entitlement.

### **How do I elect continuation coverage?**

Each qualified beneficiary has an independent right to elect continuation coverage. For example, an employee's spouse may elect continuation coverage, even if the employee does not, and a parent may elect continuation coverage for none, only one, several, or all of his or her dependent children who are qualified beneficiaries. A qualified beneficiary must use the election form provided by the Benefits Office to elect coverage. Elections must be made by the date specified in the cover letter sent with your COBRA notice. **Failure to do so will result in loss of the right to elect continuation coverage under the Program.**

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special

enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**How much does continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the total cost (including both employer and employee contributions) of coverage for a similarly situated plan participant or beneficiary who is not receiving continuation coverage. In the case of an extension of continuation coverage due to a disability, this amount may rise to 150 percent of that cost.

**When and how must I pay for continuation coverage?**

*First payment for continuation coverage*

If you elect continuation coverage, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within the 45 days, you will lose all continuation coverage rights under the Program.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Program would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Melissa Carrasquillo of the Benefits Office to confirm the correct amount of your first payment.

Your election form and your first payment for continuation coverage should be sent to Melissa Carrasquillo of the Benefits Office. Refer to the section "How do I contact?" at the end of this notice for mailing and other contact information for the University.

*Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Please note that bills are sent as a courtesy. If for some reason you do not receive a bill, you are still responsible to make timely payments. Failure to make timely payments will result in loss of coverage.

*Grace periods for periodic payments*

Although periodic payments are due on the first of the month, you will be given a grace period of 30 days to make each monthly payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Program.

**How do I get more information?**

This summary does not fully describe your continuation coverage or other rights under the Program. More information about continuation coverage and your rights under the Program is available from the Benefits Office. If you have any questions concerning the information in this Notice, contact the Benefits Office.

For more information about COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, you may contact the U.S. Department of Labor's Employee Benefits Security

Administration (EBSA) in your area, or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**What if I move or have children who do not live with me?**

In order to protect your and your family's rights, you should keep the Benefits Office informed of any changes to the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Office. If you have a spouse or any dependent children who are eligible to elect continuation coverage, but who do not live with you, please provide the Benefits Office with their names and addresses.

**How do I contact the University and the Benefits Office?**

Any notice, form, or other information that you are required to provide to the University should be sent to:

Temple University  
Attn: Benefits Office  
TASB 083-39  
1852 N. 10<sup>th</sup> Street  
Philadelphia, PA 19122  
(215) 926-2270

Premium Payments should be sent to:

Temple University  
Attn: Melissa Carrasquillo  
TASB 083-39  
1852 N. 10<sup>th</sup> Street  
Philadelphia, PA 19122  
(215) 926-2283

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## Definition of Terms

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As used in this booklet, the following terms shall have the meaning described, unless the context requires otherwise:

**ALLOWABLE CHARGES:** The term “Allowable Charge” shall mean, for Covered Drugs dispensed by a Network Pharmacy, the amount that Caremark has negotiated to pay the Network Pharmacy as total reimbursement for a Covered Drug. You will be responsible for that portion of the Allowable Charge represented by your Co-payment (see Appendix A). In the case of a Non-Network Pharmacy, the Allowable Charge is determined by Caremark based on its determination of the maximum allowable cost for a Covered Drug. Participants who obtain a Covered Drug from a Non-Network Pharmacy are responsible for any cost of such Covered Drug in excess of the Allowable Charge.

**BENEFIT ADMINISTRATOR:** The term “Benefit Administrator” shall mean CVS Caremark, which has entered into a contract with Temple University to perform prescription drug claims processing and related administrative services.

**BRAND NAME OR BRAND NAME DRUG:** The term “Brand Name” or “Brand Name Drug” shall mean a prescription drug produced by a manufacturer awarded the original patent for that specific drug or combination of drugs and satisfying requirements of the U.S. Food and Drug Administration and applicable state law and regulations.

**CO-PAYMENT:** The term “Co-payment” shall mean a specified amount which must be paid by the Participant toward the cost for filling or refilling a Prescription Drug Order for Covered Drugs.

**COSMETIC DRUG OR DRUGS USED FOR COSMETIC PURPOSES:** The term “Cosmetic” or “Cosmetic Purposes” shall mean Drugs:

- A. For other than the treatment of illness, injuries, congenital birth defect or restoration of physiological function; or
- B. For cleansing, beautifying, promoting attractiveness or altering the appearance of any part of the human body.

**COVERED DRUGS:** Generic and Brand Name Drugs which are:

- A. Prescribed for the Participant by a Health Care Practitioner who is appropriately licensed to prescribe Drugs;
- B. Prescribed for a use that has been approved by the U.S. Food and Drug Administration;
- C. Not excluded from coverage under the terms of this Program.

Insulin shall be considered a Covered Drug where Medically Appropriate. Diabetic supplies, such as syringes, strips, lancets and glucometers, are not covered.

**DENTIST:** The term “Dentist” shall mean a person who is a Doctor of Dentistry Science (D.D.S.) or a Doctor of Dental Medicine (D.M.D.), licensed and legally entitled to practice dentistry and dispense drugs.

**DEPENDENT:** The term “Dependent” shall mean:

- A. an eligible Employee’s spouse under a legally valid existing marriage, or an Employee’s eligible certified domestic partner; and

- B. an eligible Employee's children under 26 years of age (including biological children, foster children, stepchildren, children legally placed for adoption, and legally adopted children of the Employee or the Employee's spouse); and
- C. an eligible Employee's unmarried, dependent children 26 years of age or older who are incapable of self-support due to a physical or mental handicap which occurred prior to age 26, and who were enrolled for coverage as dependents prior to age 26.

**DRUG:** The term "Drug" shall mean a substance which is:

- A. Recognized in the Approved Drug Products with Therapeutic Equivalent and Evaluations (The FDA Orange Book);
- B. Intended for use in the treatment of disease or injury; and,
- C. Not a device or a component, part or accessory of a device.

**ELIGIBLE PERSON OR PARTICIPANT:** The terms "Eligible Person" or "Participant" shall mean an active full time employee of Temple University in an eligible Employment Group (as detailed in Appendix A) who is actively working or otherwise eligible for benefits or a dependent as defined in this booklet. Eligibility shall not be affected by the physical condition of an employee, and determination of eligibility by Temple University shall be final and binding for all purposes of this Program.

**EMPLOYEE:** The term "Employee" shall mean an active, full-time common law employee of Temple University (or a participating affiliate) who is a member of an Employment Group as classified by the University as eligible to participate in this Program. Persons classified by the University as independent contractors, students or temporary or seasonal employees are not eligible to participate in the Program.

**EXPERIMENTAL DRUG OR INVESTIGATIVE DRUG:** The term "Experimental Drug" or "Investigative Drug" shall mean any Drug or drug usage device or supply as determined on the advice of the general medical community, which includes but is not limited to medical consultants, medical journals and/or governmental regulations, does not accept as standard medical treatment of the condition being treated, or any such Drug or drug usage device or supply requiring federal or other governmental agency approval, which approval has not been granted at the time services were rendered.

**GENERIC DRUG:** The term "Generic Drug" shall mean all forms of a particular Prescription Drug which are:

- A. Sold by a manufacturer other than the original patent holder;
- B. Approved by the U.S. Food and Drug Administration as being generically equivalent to the Brand Name Drug; and
- C. In compliance with applicable state laws and regulations.

**HEALTH CARE PRACTITIONER:** The term "Health Care Practitioner" shall mean a Physician, Dentist, podiatrist, nurse practitioner, or other person licensed, registered and certified as required by law to prescribe Drugs in the course of his or her professional practice.

**MAINTENANCE DRUGS:** The term "Maintenance Drugs" shall mean a Covered Drug recognized by Carework for the treatment of chronic or long term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis.

**MEDICALLY APPROPRIATE or MEDICAL APPROPRIATENESS:** The terms “Medically Appropriate” or “Medical Appropriateness” shall mean Prescription Drugs that are:

- A. Appropriate for the treatment of the Participant’s condition, illness, disease or injury;
- B. Required for the direct care and treatment of Participant’s condition, illness, disease or injuries;
- C. In accordance with standards of good medical practice as generally recognized and accepted by the medical community;
- D. Not primarily for the convenience of Participant, Participant’s family or of the Pharmacy or Physician, Dentist or other Health Care Practitioner; and
- E. The most efficient and economical Prescription Drug that can safely be provided to subscriber. Prior, concurrent, periodic and/or retrospective review of medical appropriateness may be performed for Prescription Drugs dispensed under this Plan.

**NETWORK MAIL ORDER PHARMACY:** The term “Network Mail Order Pharmacy” shall mean a Network Pharmacy which has entered into an agreement with Caremark to provide the mail order prescription drug services described in this booklet.

**NETWORK PHARMACY:** The term “Network Pharmacy” shall mean a pharmacy which has been selected and credentialed by Caremark as a member of its participating pharmacy network. Network Pharmacies have agreed to charge no more than the Allowable Charge for a Covered Drug. If you utilize a Network Pharmacy, you will be responsible for any Co-payment, but not any additional amount based on charges in excess of the Allowable Charge.

**NON-NETWORK MAIL ORDER PHARMACY:** The term “Non-Network Mail Order Pharmacy” shall mean a Pharmacy that provides Prescription Drugs by means of mail order, but has not entered into an agreement with Caremark to provide such services.

**NON-NETWORK PHARMACY:** The term “Non-Network Pharmacy” shall mean a Pharmacy which is not a member of Caremark’s participating pharmacy network.

**PHARMACIST:** The term “Pharmacist” shall mean a person who is legally licensed to practice the profession of pharmacy and who regularly practices such profession in a Pharmacy.

**PHARMACY:** The term “Pharmacy” shall mean any establishment which is registered and licensed as a pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

**PHYSICIAN:** The term “Physician” shall mean a person who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), licensed and legally entitled to practice medicine and dispense Drugs.

**PRESCRIPTION DRUG:** The term “Prescription Drug” shall mean a Drug which is:

- A. Approved for distribution by the U.S. Food and Drug Administration; and
- B. Required by law to be dispensed with a Prescription Drug Order from a Health Care Practitioner who is licensed to prescribe Drugs.

**PRESCRIPTION DRUG ORDER:** The term “Prescription Drug Order” shall mean a lawfully written or verbal order of a Health Care Practitioner who is licensed to prescribe Drugs.

**PROGRAM OR PLAN:** The term “Program” or “Plan” means the Temple University Prescription Drug Program as described in this booklet, and as it may be amended from time to time.

**TEMPLE UNIVERSITY:** The terms “Temple University” or “University” shall mean Temple University -Of the Commonwealth System of Higher Education. As the context requires, it also means any affiliate of Temple University which is permitted by the University to participate in this Prescription Drug Program.

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## Claims Appeal Procedure

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If your claim or prescription drug benefit has been denied in whole or in part, you will be sent a rejection letter. This rejection letter will set forth the specific reasons for such denial. You have the right to appeal the denial. To do so, you should contact CVS Caremark's Member Services department. Once you contact Caremark with a request to appeal, you will be instructed on how to submit an appeal. A CVS Caremark Member Services representative will mail you the appropriate forms to complete. You (or your authorized representative) may submit the appeal on CVS Caremark's appeals form for this purpose, or in other written form.

You or your representative must submit the appeal to CVS Caremark in writing no later than sixty (60) days after receiving the rejection letter. You should include in your appeal an explanation stating why you think your claim should not have been denied, including a copy of the rejection letter and any other materials or information you believe may be pertinent to the claim. You may also submit issues and comments in writing.

Upon receipt of your letter and any additional information you provide, your records will be fully and fairly reviewed. The review of your appeal will be based on the terms and limitations of the Program and Caremark's medical policies and prior authorization criteria. The results of CVS Caremark's review will be sent to you normally within 60 days. In unusual cases, such as when review of your claim requires examination by qualified medical personnel, including consulting physicians, the review may take longer than 60 days. In such case, you will be notified of the delay. Such delay may not exceed an additional 60 days.

If your claim relates to your eligibility, or the eligibility of one of your dependents, for coverage under the Program (rather than a claim for Drug benefits), you may file your claim directly with Temple University. Include a detailed description of why you believe you, or your dependent, should be covered by the Program and submit any additional information or materials you believe is relevant to your claim. The University will normally advise you of its decision on appeal within sixty (60) days. In unusual cases, the review may take longer than 60 days.

Upon exhaustion of the appeals procedure, you or your authorized representative may request that a denied claim or prescription drug benefit be subject to an external review by an independent organization designated by CVS Caremark or Temple University consistent with the applicable requirements of the Patient Protection and Affordable Care Act, as amended. For more information, contact CVS Caremark.

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## Other Information

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The Prescription Drug Program is sponsored and maintained by Temple University – Of the Commonwealth System of Higher Education. You may contact the University with respect to the Program at the following address:

Mailing Address:  
Temple University  
Benefits Office  
TASB 083-39  
1852 N. 10<sup>th</sup> Street  
Philadelphia, PA 19122  
(215) 926-2270

Physical Address:  
Temple University  
Benefits Office  
2450 West Hunting Park Avenue  
1<sup>st</sup> Floor  
Philadelphia, PA 19129  
(215) 926-2270

CVS Caremark is the Benefit Administrator, providing prescription drug claims processing and related administrative services on behalf of the Program accordance with the contract with the University. CVS Caremark's Member Services department may be contacted at the following address:

CVS Caremark  
Attn: Customer Care  
P.O. Box 52115  
Phoenix, AZ 85072  
800-966-5772

CVS Caremark's Mail Service Pharmacy may be contacted at the following address:

P.O. Box 3223  
Wilkes-Barre, PA 18773-3223

Telephone Numbers:  
Members: 800-966-5772

Doctor to call in new Rx: 877-727-7455

Doctor to fax in new Rx: 866-308-8234 (Must use a CVS Caremark Form for Prescriptions which is available on the Caremark Web site.)

The Program will be interpreted and construed in accordance with the laws of the Commonwealth of Pennsylvania. The Program is not subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA).

All benefits under the Program are paid for from the general assets of the University. Participants may be required to pay a portion of the cost of coverage. The Program's records are maintained on the basis of the fiscal year.

## APPENDIX A

### EMPLOYMENT GROUP INFORMATION

#### **Eligible Employment Group:**

Employees classified by the University as full-time who are: non-union executive, administrative, supervisory and staff employees, Law School employees and faculty, employees and faculty represented for collective bargaining purposes by the Temple Association of University Professionals (TAUP), and employees represented for collective bargaining purposes by the American Federation of State, County and Municipal Employees (AFSCME).

For the initial effective date of coverage for your group, contact the University's Benefits Office. Coverage will not become effective unless and until you have enrolled for coverage, including authorization of payroll deductions for your share of the cost of coverage.

#### **Eligible Retiree Group:**

Retirees who are eligible to participate in and who make participant contributions to the Temple University Retiree Health Benefits Pre-Funding Plan in accordance with the rules of such Plan, and eligible retirees who retired prior to January 1, 1995.

#### **Co-payment:**

The Plan will pay 70% of the Allowable Charge for a Non Preferred Brand Covered Drug dispensed at a Caremark Network Pharmacy. You will be responsible for paying the other 30% of the Allowable Charge. The Plan will pay 80% of the Allowable Charge for a Preferred Brand Covered Drug dispensed at a Caremark Network Pharmacy. You will be responsible for paying the other 20% of the Allowable Charge. The Plan will pay 90% of the Allowable charge for a Covered Generic Drug dispensed at a Caremark Network Pharmacy. You will be responsible for paying the other 10% of the Allowable Charge. Prescription drugs dispensed at Non-Network Pharmacies will be reimbursed by the Plan at 50% of the Allowable Charge. You are responsible for the balance.