



# Personal Choice 65 Prescription Drug Benefits Rider An Addendum to Your Evidence of Coverage

Effective January 1, 2008  
through December 31, 2008

**1-888-718-3333**  
**TTY/TDD: 1-888-857-4816**  
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**8 a.m. – 8 p.m.**

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## **INTRODUCTION TO THE PERSONAL CHOICE 65 OUTPATIENT PRESCRIPTION DRUG BENEFIT**

The purpose of this section is to give the details about the Personal Choice 65 outpatient prescription drug benefit. This benefit covers certain drugs that require a prescription and that have been approved by the Food and Drug Administration (the FDA) for the intended purpose. The Personal Choice 65 prescription drug benefit is above and beyond the basic Original Medicare benefit. Original Medicare covers a limited number of prescription drugs, usually those that must be administered by a health professional. See [Section 3](#) of your Evidence of Coverage book for more information on Original Medicare-covered drugs. Original Medicare-covered prescriptions do not apply toward any applicable annual prescription benefit maximum (discussed below). If you have outpatient prescription drug coverage, please refer to your appropriate Schedule of Copayments and Prescription Drug Limitations for your specific maximum coverage amounts.

Prescription drug benefits will be available for covered drugs or supplies dispensed by a prescription order for use when you are not an inpatient. When you are in an inpatient setting, e.g., hospital or skilled nursing facility, prescription medications are covered according to Medicare guidelines.

### **PRESCRIPTION DRUG BENEFITS ARE SUBJECT TO COPAYMENTS & LIMITATIONS AS SHOWN ON THE SCHEDULE OF COPAYMENTS & PRESCRIPTION DRUG LIMITATIONS**

#### **How does the prescription benefit work?**

Benefits will be provided for covered prescription drugs and medicines prescribed by a physician and dispensed by a licensed pharmacy up to the benefit period maximums shown on the Schedule of Copayments and Prescription Drug Limitations. Benefits for prescription drugs are available for up to a 30-day supply, when dispensed from a retail pharmacy.

Charges for immunosuppressive drugs incurred within 44 months of the patient's discharge from an inpatient admission for covered transplant services will not accrue to any benefit period prescription drug maximum amount, nor will charges incurred for Medicare approved self-administered drugs and biologicals accrue to that benefit period maximum amount. Immunosuppressive drugs are covered according to Medicare guidelines.

Benefits are also available for diabetic supplies such as blood testing strips, insulin syringes and lancets, up to a 90–100 day supply per prescription or refill dispensed by a pharmacy.

#### **IMPORTANT NOTE**

**If you have coverage through your former employer, Health and Welfare Fund or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.**

## Prior authorization (approval in advance)

In certain cases, Personal Choice 65 may determine that the use of certain covered prescription drugs for a member's medical condition requires your primary care physician or plan specialist to obtain pre-approval from Personal Choice 65 to determine medical necessity. Personal Choice 65 reserves the right to apply eligible dispensing limits for certain covered prescription drugs. These limits result from age, gender or quantity limits as conveyed by the Food and Drug Administration (FDA) or the plan's (in-network) Pharmacy and Therapeutics Committee.

The following prescription drugs require prior authorization (approval in advance):

- Viagra®
- MUSE®
- Caverject®
- Edex®
- Celebrex®
- Enbrel®
- Provigil®
- Thalomid®
- Mobic®
- Prevacid®
- AcipHex®
- Levitra®
- Humira®
- Kineret®

This list is subject to change.

## Requesting prior authorization (approval in advance)

1. The prescribing physician completes a prior authorization (approval in advance) form available from Personal Choice 65 by calling **1-888-671-5280**, or writes a letter describing the medical necessity and submits to Personal Choice 65's pharmacy services department. This can be done by fax at **215-241-3073** or **1-888-671-5285**. You can obtain the form by calling Member Services, but it must be completed and submitted by your physician.
2. The plan's pharmacy department will review the prior authorization (approval in advance) form or letter of medical necessity. If the pharmacist cannot approve the request based on established review criteria, a medical director will review the document.
3. A decision is made regarding the request.
4. If approved, the prescribing physician will be notified of the approval via fax, and the system will be coded with the approval. You can call Member Services to find out if your request was approved.
5. If denied, the prescribing physician will be notified by fax and letter, and you will be notified by letter.
6. The appeals process will be described on the denial letter should you choose to appeal the decision.

## WHAT IS A “FORMULARY?”

If you have prescription drug coverage, the Personal Choice 65 prescription drug benefit includes a drug formulary which is a list of FDA approved prescription drugs that have been selected by Personal Choice 65 physicians and pharmacists based upon the safety, efficacy and cost of those drugs. Whether a drug is on the formulary list or not may affect how much you have to pay when you fill a prescription for a covered drug. PRESCRIPTION DRUG BENEFITS ARE SUBJECT TO COPAYMENTS & LIMITATIONS AS SHOWN ON THE SCHEDULE OF COPAYMENTS & PRESCRIPTION DRUG LIMITATIONS. The Personal Choice 65 formulary is a comprehensive list of medications used by Personal Choice 65 physicians to guide their medication prescribing decisions. The Personal Choice 65 formulary was created by a group of doctors and pharmacists. They picked the drugs that are on this formulary list based on how safe and effective they are, and how much they cost. We call the drugs that are on this list “formulary drugs.” We call drugs that are not on the list “non-formulary drugs.” All of the medications on this list of drugs are reviewed and approved by Personal Choice 65 providers for use by Personal Choice 65 members. The formulary is reviewed and revised at least twice a year and is subject to change without advance notice throughout the year. The Personal Choice 65 formulary includes FDA-approved brand-name drugs.

You may use the Personal Choice 65 grievance process as described in [Section 10](#) of the Evidence of Coverage booklet if you have complaints about which drugs are or are not included in the formulary, or about the administration of the formulary.

There is no formulary for generic drugs. However, all other terms and conditions set forth in your Evidence of Coverage (EOC) remain in effect.

### How can you get a copy of the formulary?

You may obtain a copy of the Personal Choice 65 formulary by calling Member Services at the number listed on the front of the EOC booklet.

## CAN YOUR PRESCRIPTION DRUG FORMULARY LIST CHANGE DURING THE YEAR?

**The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year.** The formulary is a list of drugs. A change in our drug formulary list could affect which drugs are covered for you. Note that the formulary list applies only to the covered services listed in the Benefits Chart under the heading that says, “Personal Choice 65 prescription drug benefit (outpatient prescription drugs).”

### Important Notice: When A Generic Drug Is Not Available

The decision to classify a drug as brand or generic is made by the plan and the drug manufacturers who list this information in the First Data Bank. The First Data Bank is a national registry of all drugs available in the United States. Drug manufacturers provide the First Data Bank with a list of their drugs, prices and whether a drug is classified as a generic or brand-name drug.

There are certain brand-name drugs that do not have generic equivalents. Examples of these include, but are not limited to, Insulin and Premarin®. These brand-name drugs are EXCLUDED from your coverage if you have chosen the benefit plan that offers generic prescriptions only. If you or your physician request a brand-name drug for which there is no generic equivalent, you will be responsible for paying the entire cost of the drug to the pharmacy. Prior authorization (approval in advance) by the plan may still be required. Please refer to the Medicare formulary to determine whether a brand-name drug is excluded from coverage under your plan (in-network). **Employer groups may vary, contact your benefits administrator or Member Services for details.**

## HOW DO YOU FILL YOUR PRESCRIPTION?

**Drugs from a plan (in-network) pharmacy**—When you show your ID card, you can obtain covered drugs or supplies furnished by a pharmacy for the applicable drug copayment for each prescription order or refill. The quantity of a prescription drug dispensed per drug copay from a pharmacy pursuant to a prescription order or refill is limited to thirty (30) consecutive days.

### Through a plan (in-network) pharmacy:

- A 1-30 day supply of a prescription drug may be obtained for one (1) times the drug copay.
- A 31-60 day supply of a maintenance prescription drug may be obtained for two (2) times the drug copay.
- A 61-90 day supply of a maintenance prescription drug may be obtained for three (3) times the drug copay.

**Drugs from a non-plan (out-of-network) pharmacy**—You will be reimbursed for covered drugs or supplies furnished by a non-participating pharmacy when you submit acceptable proof of payment with a direct reimbursement form. Reimbursement for covered drugs or supplies will not exceed thirty percent (30%) of the usual and customary charge. You will be entitled to reimbursement at the in-network benefit level, only if your purchase is related to covered services for emergency care or urgent care within the United States. Drugs purchased outside the United States are covered at the out-of-network benefit level. All claims for payment must be received within ninety (90) days of the date of proof of purchase. Direct reimbursement forms may be obtained by contacting the Member Services Department at the telephone number on your ID Card.

### Through a mail service pharmacy:

Benefits shall also be provided for covered prescription drugs ordered by mail if a covered person or prescribing Physician submits to a preferred mail-order pharmacy a written prescription drug order specifying the amount of the covered prescription drug to be supplied. Benefits shall be available for up to a 90-day supply of a covered prescription drug, subject to the amount specified in the prescription drug order and applicable law.

- A 1-30 day supply of a prescription drug may be obtained for one (1) times the drug copay.
- A 31-90 day supply of a maintenance prescription drug may be obtained for two (2) times the drug copay.

### IMPORTANT NOTE

**If you have coverage through your former employer, Health and Welfare Fund or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.**

## EXCEPTION PROCESS

In certain circumstances, members may request an exception to the Personal Choice 65 formulary. Prescribing providers may request coverage of non-formulary medications at the formulary benefit level on behalf of members for the following reasons:

- Member has an allergy to or contraindication to use of current formulary medication(s)
- Member has not had a clinical response to current formulary medication(s)

The prescribing provider must submit a request to the pharmacy department. Documentation of allergies, contraindications, etc. must be included. All requests must be approved or denied by a medical director.

Members may file a grievance if they have a complaint about the plan formulary or its administration.

## **PRESCRIPTION DRUG LIMITATIONS**

1. A pharmacy need not dispense a prescription order which, in the pharmacist's professional judgment, should not be filled, without first consulting with the prescribing physician.
2. Prescription refills will not be provided beyond six (6) months from the most recent dispensing date.
3. Prescription refills will be dispensed only if 75% of the previously dispensed quantity has been consumed based on the dosage prescribed. Example: If you have a prescription filled on January 1 for a quantity of 30 pills, which is a 30-day supply, you can refill on January 23 leaving you a seven-day supply. If you go for another 30-day supply, you will now have a 37-day supply. You can refill after 75% of your 37-day supply is used.
4. You must present your Identification card, and the existence of prescription drug coverage must be indicated on the card.
5. You will pay to a plan pharmacy:
  - a. One hundred percent (100%) of the cost for a prescription drug dispensed when you fail to show your Identification Card. A claim for reimbursement for covered drugs or supplies may be submitted to Personal Choice 65; or
  - b. One hundred percent (100%) of a non-covered drug or supply; or
  - c. The prescription drug copayment as specified in the Schedule of Copayments and Limitations.
6. In certain cases, Personal Choice 65 may determine that the use of certain covered prescription drugs for a member's medical condition requires your primary care physician or plan specialist to obtain prior authorization from Personal Choice 65 to determine medical necessity.

Personal Choice 65 reserves the right to apply eligible dispensing limits for certain covered prescription Drugs. These limits result from age, gender, or quantity limits as conveyed by the FDA or plan's Pharmacy and Therapeutics Committee.

## **PRESCRIPTION DRUG EXCLUSIONS**

The following are excluded from your prescription drug benefits:

1. Drugs used for experimental or investigative purposes.
2. Drugs used for cosmetic purposes, such as wrinkle remover or hair growth.
3. Health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents.
4. Vitamins, unless they require a prescription and are medically appropriate/medically necessary for the treatment of a specific illness, as determined by the plan (in-network).
5. Drugs available over-the-counter, even if prescribed by the physician.
6. Drugs which have no currently accepted medical use for treatment in the United States.

7. Drugs dispensed to a member while a patient is in a hospital, nursing home or other institution (inpatient medications are covered according to Medicare guidelines).
  8. Smoking deterrent agents.
  9. Administration or injection of drugs.
  10. Prescription drugs not approved by the plan or prescribed drug amounts exceeding the eligible dosage limits established by the plan.
  11. Non-formulary injectable drugs.
  12. Prescription drugs that are subject to prior authorization (approval in advance) for medical necessity and are dispensed without pre-approval by the plan.
  13. Devices of any type even though such devices may require a prescription order. This includes, but is not limited to contraceptive devices, therapeutic devices or appliances, hypodermic needles, syringes or similar devices. This exclusion does not apply to devices used for the treatment or maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin.
  14. Prescription drugs obtained through mail-order prescription drug services of a non-plan (out-of network) mail-order pharmacy.
  15. Drugs prescribed and administered in the physician's office (except as covered by Medicare).
  16. Contraceptive drugs.
  17. Replacement of lost, stolen, returned, or damaged prescriptions are not covered.
- All other terms and conditions set forth in your Evidence of Coverage remain in effect.

## **IMPORTANT DEFINITIONS**

**For the purpose of understanding your Prescription Drug benefits, the terms below have the following meaning:**

**ANNUAL MAXIMUM**—(No Carry Over)—this is the total dollar amount which the plan will cover each calendar year. For each prescription, the plan (in-network) will take the cost of the prescription drug; minus any copayments paid by the member. Each time a prescription is filled, these costs will be added until the annual maximum is reached. Members may not carry over any unused benefit allowance.

**APPEAL**—Any of the procedures that deal with the review of adverse organization determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by the Medicare Advantage Organization, an independent review entity, hearings before Administrative Law Judges (of the Social Security Administration), review by the Board, and judicial review.

**BRAND-NAME DRUG**—A single source, FDA-approved drug manufactured by one company for which there is no FDA-approved generic available. Examples include, but are not limited to Lipitor®, Premarin® and Insulin.

**CALENDAR YEAR**—A twelve (12) month period that begins on January 1 and ends twelve (12) consecutive months later, on December 31.

**CONTRACEPTIVE DRUGS**—FDA approved drugs requiring a prescription order to be dispensed for the use of contraception. These include oral contraceptives (birth control pills), IUDs (Intrauterine Devices), diaphragms, and topical patches.

**CONTROLLED SUBSTANCE**—Any medicinal substance as defined by the Drug Enforcement Administration which requires a prescription order in accordance with the Controlled Substance Act-Public Law 91-513.

**COVERED DRUGS OR SUPPLIES**—Drugs or supplies approved under Federal Law by the Food and Drug Administration for general use, and limited to the following:

- A. Prescription drugs prescribed by a primary care physician or plan specialist and when required, preapproval by Personal Choice 65 subject to the prescription drug exclusions, limitations and other exclusions listed in your Evidence of Coverage;
- B. Compounded prescription drugs containing at least one legend drug or controlled substance in an amount requiring a prescription order.

**EFFECTIVE DATE OF COVERAGE**—The date coverage begins for a member under this contract. All coverage begins at 12:01 A.M. on the date reflected on the records of IBC. The member will receive written notification of the effective date from Personal Choice 65 upon Personal Choice 65's receipt of confirmation of eligibility from CMS.

**ERECTILE DYSFUNCTION DRUGS**—FDA-approved drugs requiring prescription order to be dispensed for erectile dysfunction. These include, but are not limited to, Viagra® (sildenafil), Caverject® (alprostadil), MUSE®, Levitra®, and related drugs. These drugs require pre-approval by Personal Choice 65.

**EXCLUSION**—A service or supply specified in the prescription drug exclusion section of this contract for which no benefits will be provided under the terms of this contract.

**EXPERIMENTAL OR INVESTIGATIVE PROCEDURES OR ITEMS**—Drugs, devices, medical treatments, items or procedures that have not been approved by the FDA (Food and Drug Administration).

**FORMULARY** (Select List Of Drugs)—An extensive list of FDA Approved prescription drugs that have been selected by the plan (in-network) pharmacy and Therapeutic Committee on the basis of sound medical data, effectiveness, safety and cost. This committee is comprised of both plan medical directors as well as network physicians and pharmacists. The formulary drugs are the drugs which the plan (in-network) will cover with a lower copayment, subject to limitations and exclusion if they are prescribed by your primary care physician or specialist. The plan formulary does not apply to members who have elected an unlimited generic only plan benefit option. The formulary is updated bi-annually in January and in July. Members can obtain the latest formulary information on the plan's website at [www.site65.com](http://www.site65.com) and receive updates in Personal Choice 65's quarterly newsletter.

**GENERIC DRUG**—The equivalent version of a brand-name drug produced when the patent on the brand-name drug has expired. Generic drugs have the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. The generic drug may cost at least 20% less than the brand version in order to be assessed the generic copayment at the pharmacy.

**GRIEVANCE**—Any complaint or dispute other than one involving an organization determination.

**INCURRED**—A charge shall be considered incurred on the date the member receives the service or supply for which the charge is made.

**LEGEND DRUG**—Any medicinal substance which is required by the Federal Food, Drug, and Cosmetic Act to be labeled as follows: “Caution: federal law prohibits dispensing without a prescription.”

**LIMITATIONS**—The maximum number of covered services, measured in number of dollars, visits or days, that are eligible for coverage. Limitations may vary depending on the type of program and covered services provided. Limitations, if any, are identified in the Schedule of Copayments and Limitations.

**MAIL SERVICE PHARMACY**—The participating pharmacy contracted by Personal Choice 65 or an agent of Personal Choice 65 to provide prescription drugs through the mail.

**MAINTENANCE PRESCRIPTION DRUG**—A Prescription Drug, as determined by Personal Choice 65, used for the ongoing treatment of chronic or long term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis.

**NON-FORMULARY DRUG (Non-Preferred List of Drugs)**—These are drugs which are not listed on the plan’s (in-network) formulary. However, these drugs are covered with a higher copayment for some benefit options and are otherwise available to members at the plan’s network pharmacy discount rate.

**NON-PLAN (OUT-OF-NETWORK) PHARMACY**—A pharmacy which has not entered into a written agreement with or an agent of Personal Choice 65 to render covered services to members.

**NON-PLAN (OUT-OF-NETWORK) MAIL-ORDER PHARMACY**—A mail-order pharmacy same as above.

**OPTIONAL SUPPLEMENTAL BENEFITS**—Additional non-Medicare covered benefits beyond the benefits included in basic benefits, which may be elected at a member’s option. There is an additional plan premium associated with optional supplemental benefits. Members of Personal Choice 65 must voluntarily elect optional supplemental benefits in order to receive them.

**PHARMACIST**—An individual, duly licensed as a pharmacist by the state board of pharmacy or other governing body having jurisdiction, and who is employed by or associated with a pharmacy and has the authority to dispense prescription drugs.

**PLAN (IN-NETWORK) MAIL-ORDER PHARMACY**—A pharmacy that is a member of the Personal Choice 65 network and has agreed to a rate of reimbursement determined by contract to provide members with mail-order prescription drug services.

**PLAN (IN-NETWORK) PHARMACY**—A pharmacy that has an agreement with Personal Choice 65 to provide the member with medication(s) prescribed by the member’s contracting medical provider in accordance with Personal Choice 65.

**PRESCRIBE OR PRESCRIBED**—To write or give a prescription order.

**PRESCRIPTION DRUG**—Prescription drugs shall mean drugs or medications:

1. which by law require a Prescription order to dispense;
2. which are approved by the plan and approved for distribution by the federal government;
3. for which medical appropriateness/medical necessity exists; and
4. which have been approved by the Federal Food and Drug Administration and only for those uses for which they have specifically been approved by the Federal Food and Drug Administration.

**PRESCRIPTION DRUG COPAYMENT (DRUG COPAY)**—The amount as shown in the Schedule of Copayments charged to the member by the plan participating pharmacy or the mail service pharmacy for the dispensing or refilling of any prescription order. The member is responsible at the time of service for payment of the drug copay directly to the plan participating pharmacy or mail service pharmacy. The prescription drug copayment does not count toward the maximum(s).

**PRESCRIPTION ORDER OR REFILL**—The authorization for a prescription drug issued by a primary care physician or specialist who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

**PRESCRIPTION UNIT**—The maximum amount (quantity) of medication that may be dispensed per prescription for a single copayment. For most oral medications, the prescription unit represents up to a thirty (30)-day supply of medication. The prescription unit for other medications will represent a single container, inhaler unit, package, or course of therapy. For drugs that could be habit-forming, the prescription unit is set at a smaller quantity for your protection and safety.

**PRIOR AUTHORIZATION (APPROVAL IN ADVANCE)**—The prior authorization (approval in advance) which the primary care physician or specialist must obtain from Personal Choice 65 to confirm coverage for certain covered prescription drugs for a member's medical condition to determine medical necessity. Such prior authorization (approval in advance) must be obtained by the primary care physician or specialist prior to providing the prescription drug. Personal Choice 65 also reserves the right to apply eligible dispensing limits for certain covered prescription drugs. These limits result from age, gender or quantity limits as conveyed by the FDA or Personal Choice 65's Pharmacy and Therapeutics Committee.

**STATE RESTRICTED DRUG**—Any non-federal legend drug which, according to state law, may not be dispensed without a prescription order.









