PEBTF BENEFIT NEWS for Retiree Members

Prescription Drug Plan Moves to CVS Caremark Beginning July 1, 2012 — All Retirees

On July 1, 2012, your prescription drug plan will be administered by CVS Caremark. There is no change to the prescription drug copayments. There are changes to the prescription drug formulary so costs will change for some medications. See page 3 for more information on the formulary.

To make this transition as easy as possible for you, there are some things you need to do:

- Pay attention to all information you receive from the PEBTF and CVS Caremark. Everything will be sent to your mailing address. Please update your mailing address with the State Employees' Retirement System (SERS).
- Use your new CVS Caremark prescription drug card beginning July 1, 2012.
- Visit the PEBTF website (www.pebtf.org) for more information about the prescription drug plan. Click on the button, ***Prescription Drug Plan – July 1, 2012***, which is found on the left side of the home page.

About CVS Caremark

CVS Caremark is one of the country's largest pharmacy benefit managers (PBMs) covering more than 60 million members.

CVS Caremark is a market leader in mail order pharmacy, retail pharmacy, specialty pharmacy and retail clinics.

New Prescription Drug Card

You will receive a CVS Caremark prescription drug card prior to July 1. It is very important that you present the CVS Caremark prescription drug card every time you fill a prescription at the pharmacy on or after July 1, 2012. If you do not present the CVS Caremark prescription drug card, you will have to pay the entire cost of your medication because the pharmacist will not know you have CVS Caremark coverage.

The welcome packet, which includes the prescription drug card, will be sent to your mailing address. Look for a regular-sized envelope with the PEBTF's return address in the upper left corner. A red box with "Your Prescription Benefits" will also appear on the front of the envelope.

You will receive two prescription drug cards. Additional cards may be ordered on the CVS Caremark website after July 1, 2012 or by calling the PEBTF or CVS Caremark. You can also print a temporary card by logging into your account on the CVS Caremark website after July 1.

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What's Inside

	Up to 30-day Supply	Up to 90-day Supply		
	Retail Network Pharmacy	CVS Pharmacy (Starting July 1)	Rite-Aid Pharmacy	CVS Caremark Mail Service Pharmacy
Generic	$10	$15	$20	$15
Preferred Brand-Name	$18*	$27*	$36*	$27*
Non-Preferred Brand-Name	$36*	$54*	$72*	$54*

*Plus the cost difference between the brand and the generic, if one exists

Your Prescription Drug Copayments

There is no change to the prescription drug copayments. ***New for July 1***, you will be able to get up to a 90-day supply at your local CVS pharmacy at the same low price as mail order. Additionally, you can continue to use a Rite Aid pharmacy to obtain 90-day supplies.

Obtaining Prescription Drugs – Up to 30-day Supplies

You may obtain up to a 30-day supply of your prescription medication at any network pharmacy. The CVS Caremark network has more than 65,000 pharmacies including more than 7,300 CVS/pharmacy stores. Most national chains are part of the network. In Pennsylvania, you'll find ACME Pharmacy, Giant Pharmacy, Rite Aid Pharmacy and Wegman's Pharmacy are in the network. You can find a list of the participating major chain pharmacies at www.pebtf.org. After July 1, you can also log into the CVS Caremark website to find all of the participating pharmacies in your ZIP code using their Pharmacy Locator tool.

Obtaining Long-Term Maintenance Medications – Up to 90-day Supplies

You may also obtain up to a 90-day supply of your prescription medication. This feature is particularly useful if you take medications on an on-going basis for a chronic condition such as high blood pressure, high cholesterol, diabetes, heart conditions or asthma. You may obtain up to 90-day supplies of your medications as follows:

- By mail through CVS Caremark Mail Service Pharmacy
- At a Rite Aid Pharmacy
- At a CVS Pharmacy – new for July 1, 2012

Using Mail Order

If you have remaining refills on prescriptions at Medco Mail Order, these will be transferred to CVS Caremark. You will be able to order these prescriptions from CVS Caremark Mail Service starting on July 1, 2012. The only exceptions are compound medications and controlled substances, such as oxycodone, because these prescriptions, by law, are not allowed to be transferred between prescription providers. If you have existing refills for these types of medications, ask your doctor for a new prescription and mail it to CVS Caremark after July 1. A CVS Caremark Mail Service Order Form will be included in your welcome packet that you will receive prior to July 1.

After July 1, you will also have the ability to obtain 90-day supplies at a CVS/pharmacy. There are a number of ways to transfer your mail order prescription from CVS Caremark Mail Service to a CVS/pharmacy. First, you can contact CVS Caremark customer care (the telephone number will be provided in your welcome kit and on your prescription drug card) and request that your prescription be transferred to your local CVS/pharmacy. Secondly, you can initiate a transfer through your CVS Caremark online account. Lastly, you can work directly with the pharmacist at your local CVS/pharmacy to initiate the transfer of your prescription. **You must wait until after July 1 to initiate this process.**

Formulary

All PBMs have a formulary, which is a list of generic and brand-name drugs preferred by the plan. CVS Caremark has its own formulary list, as does Medco, and these lists differ.

To save money with your prescription drug plan, it is best to chose generic medications. You will pay a lower copayment for all generic medications. Preferred brand-name drugs are available at a slightly higher copayment, plus the cost difference between the brand-name and the generic, if a generic exists.

Non-preferred brand-name drugs, which are drugs that are not on the formulary have the highest copayment under the prescription drug plan. In addition, you must pay the cost difference between the brand-name and the generic, if a generic exists.

CVS Caremark will mail a letter to you if you recently filled a prescription for a drug that may have a higher cost after July 1st, based on the formulary change. The letter, which will be mailed to you in early May, will list alternative medications that can be obtained at a lower cost under the prescription drug plan. This letter will be sent to you well in advance of the July 1 date so you may discuss alternatives with your physician.

Again, please pay attention to all mail that you receive from CVS Caremark or the PEBTF during this transition.

Formulary Exclusions

There is a list of drugs that are not covered by CVS Caremark. If you take one of these drugs, you will receive a letter in early May listing alternative drugs that are covered by the plan. After July 1, 2012, you will no longer receive coverage for a non-covered drug and will have to pay the entire cost unless you receive a prior authorization from CVS Caremark. If you are taking a non-covered drug, you should talk to your doctor about transitioning to a covered drug. If your doctor thinks there is a clinical reason why one of the covered alternatives won't work for you, your doctor may contact CVS Caremark.

Specialty Medications

Specialty medications are used to treat complex conditions and usually require injection and special handling. If you take a specialty medication, you will receive a letter in early May introducing the new CVS Caremark Specialty Pharmacy. After July 1, if you use a pharmacy other than the CVS Caremark Specialty Pharmacy or a Rite Aid pharmacy to purchase specialty medications, you will be responsible for the full cost of each prescription. You may then file a Direct Claim Form. The amount reimbursed to you, however, will be limited to the amount that would have been paid to the specialty pharmacy and may result in significant out-of-pocket costs.

Prior Authorizations

There are times when a drug has to be authorized in advance by your doctor. The prior authorization process ensures that you are receiving the appropriate drugs for the treatment of specific conditions and in quantities approved by the U.S. Food and Drug Administration (FDA). Doctors are familiar with the prior authorization process. For most of the drugs that appear on the prior authorization list, the process takes place at the pharmacy and the pharmacist contacts your doctor. Your doctor will have to provide the necessary information to CVS Caremark in order to process the prior authorization of your medication. If you have an existing prior authorization that has not expired, you will not have to get a new one – it will be transferred to CVS Caremark. However, you will be required to obtain a new prior authorization once it expires.

Other Safety Controls Continue Under the Prescription Drug Plan

Your prescription drug plan continues to have the following safety controls:

Quantity Limits: There are certain prescription drugs that are subject to quantity limits. You may find that the quantity of a medication you receive and/or the number of refills is less than you expected. Pharmacists must adhere to certain federal and state regulations and recommendations by the manufacturer or PBM that restrict the quantity dispensed for each prescription and/or the number of refills.

Step Therapy: When many different drugs are available for treating a medical condition, it is sometimes useful to follow a stepwise approach for finding the best treatment. The first step is usually a simple, inexpensive treatment that is known to be safe

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All Retirees

Obtaining Diabetic Supplies

For Non-Medicare Eligible Members – coverage based on date of retirement:

Some of your diabetic supplies are covered by the prescription drug plan and other supplies are covered by the durable medical equipment (DME), prosthetics, orthotics, medical supplies and diabetic supplies benefit administered by DMEnsion Benefit Management. The telephone number for DMEnsion appears below and is also on your medical plan ID card.

	RETIRED PRIOR TO 7/1/04	RETIRED ON OR AFTER 7/1/04
Insulin	Covered under the prescription drug plan with a copay	
Syringes/Needles Lancets Test Strips	Covered under the Prescription Drug Plan with a copay	Covered by DMEnsion 888-732-6161
Insulin Pump Glucometer	Covered by DMEnsion 888-732-6161	

For Medicare Eligible Members:

Some of your diabetic supplies are covered by the prescription drug plan and other supplies are covered by the Medicare HMO or Medicare PPO.

Insulin	Covered under the prescription drug plan with a copay
Syringes/Needles	Covered under the Prescription Drug Plan with a copay
Lancets Test Strips Insulin Pump Glucometer	Covered under your Medicare HMO or Medicare PPO plan

Prescription Drug Plan *Continued from Page 3*

and effective for most people. Step therapy is a type of prior authorization that requires that you try a first-line therapy before moving to a more expensive drug. The first-line therapy is the preferred treatment for most people. If the treatment doesn't work or causes problems, the next step is to try a second-line therapy.

You will be required to use a first-line drug before you can obtain a prescription for a second-line drug on the following classes of drugs:

- ACE's and ARB's which are used for hypertension
- COX-2 or NSAID drugs which are used for pain and arthritis

To Find Out More Information About Your Prescription Drug Plan

- Visit www.pebtf.org. Click on the button, ***Prescription Drug Plan – July 1, 2012***, which is found on the left side of the home page. More information will be posted on the website as it becomes available.
- Watch for the summer edition of ***PEBTF Benefit News***, which you will receive in mid-June.
- Contact the PEBTF at 1-800-522-7279 with any questions.

Visit www.pebtf.org and click on Prescription Drug Plan – July 1, 2012 for more information about your prescription drug plan

Where Should I Go For Care?
Helping you Choose the Right Care Center

Many of you have seen urgent care or convenience care centers popping up in your area. Here is a quick guide to help you figure out where to go when you need medical care.

Care Center	Why would I use this care center?	What type of care would they provide?*	What are the costs** and time considerations?
Doctor's Office	You need routine care or treatment for a current health issue. Your primary care doctor knows you and your health history, can access your medical records, provide preventive and routine care, manage your medications and refer you to a specialist, if necessary.	• Routine checkups • Immunizations • Preventive services • Manage your general health	• Requires a copayment for HMO and PPO network providers • Normally requires an appointment • Little wait time with scheduled appointment • Cost to REHP: $105
Convenience Care Clinic (HMO members may need a referral - check with your plan)	You can't get to your doctor's office, but your condition is not urgent or an emergency. Convenience care clinics are often located in malls or retail stores offering services for minor health conditions. Staffed by nurse practitioners and physician assistants.	• Common infections (e.g.: strep throat, sinus infection) • Minor skin conditions (e.g.: poison ivy) • Flu shots • Minor cuts • Ear aches	• Requires a copayment for HMO and PPO network providers • Walk-in patients welcome with no appointment necessary, but wait times can vary • Cost to REHP: $73
Urgent Care Center (HMO members may need a referral - check with your plan)	You may need care quickly, but it is not an emergency and your primary care physician may not be available. Urgent care centers offer treatment for non-life threatening injuries or illnesses. Staffed by qualified physicians.	• Respiratory disorders • Strains, sprains • Minor broken bones (e.g.: finger) • Minor infections • Minor burns • X-rays	• Requires a copayment for HMO and PPO network providers • Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first • Cost to REHP: $175
Emergency Room	You need immediate treatment of a very serious or critical condition. The ER is for the treatment of life-threatening or very serious conditions that require immediate medical attention. Do not ignore an emergency. If a situation seems life threatening, take action. Call 911 right away.	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Major burns • Spinal injuries • Severe head injury • Difficulty breathing • Major broken bones	• $50 copayment (waived if admitted as an inpatient) – HMO and PPO options • Open 24/7, but waiting times may be longer because patients with life-threatening emergencies will be treated first • Cost to REHP: $1,300

* Sample list of services and may not be all-inclusive.

** Costs and time information represent averages only and are not tied to a specific condition or treatment. The chart shows that the emergency room setting is the most costly and how choosing an alternative setting for non-emergencies can help the REHP save money.

Source: UnitedHealthcare

Benefit News You Need to Know

Emergency Room Visits and the Rabies Vaccine

Non-Medicare Eligible Retirees:

The REHP Plan of Benefits requires that all follow-up care after an emergency room visit be scheduled in your doctor's office.

There is an exception to this rule for rabies vaccine after exposure, and this change was effective January 19, 2012.

The rabies vaccine, including Rabies Immune Globulin (when medically necessary), is covered as a precaution after an animal bite or other exposure and not as a preventive immunization. Not all doctors' offices stock the vaccine, so you may visit the emergency room for the initial vaccine injection and all follow-up vaccine injections. The $50 emergency room copayment (for the HMO or PPO option) will be charged for each return visit to the emergency room.

If your primary care physician's office has the vaccine, you will pay the $15 copayment (for the HMO or PPO option).

Medicare Eligible Retirees: Contact your Medicare HMO or Medicare PPO if you have any questions about coverage for the rabies vaccine.

About the Rabies Vaccine

A person who is exposed and has never been vaccinated against rabies should get four doses of rabies vaccine – one dose right away and additional doses on the third, seventh and fourteenth days after exposure. In addition, another shot called Rabies Immune Globulin will be administered at the same time as the first dose. A person who has been previously vaccinated should get two doses of rabies vaccine – one right away and another on the third day after exposure. Rabies Immune Globulin is not needed in this case.

Retiree Survivor Spouse Benefits

Part of your retirement planning most likely includes providing for your family if something should happen to you. No one wants to think about the death of a loved one, but it is reassuring to know that spouses can continue health benefits when a retiree dies.

If you retired from the commonwealth with enough years of service, you and your spouse continue to have retiree health benefits. Your spouse is eligible for benefits if you should die.

In the event of your death, your spouse may continue health benefits on a self-pay basis. The monthly premium may be paid directly to the PEBTF.

A State Employees' Retirement System (SERS) Counselor provides information on survivor spouse coverage at the time of retirement. If you have questions about survivor spouse coverage, you may contact the PEBTF.

Your Benefit Questions Answered

Do you have a question about your PEBTF benefits that you would like to appear in the newsletter? Submit your question to Communications@pebtf.org, mail it to Communications, PEBTF, 150 S. 43rd Street, Harrisburg, PA 17111-5700 or fax it to Communications, 717-561-1696. Please include your full name, address and daytime phone number. Only your first name will appear in print. If the PEBTF publishes your question in a future newsletter or in the FAQ section of the PEBTF website, you will receive a pedometer to help you walk your way to better health.

I am enrolled in the Aetna Medicare℠ Plan (PPO). Are monies paid toward the in-network deductible also applied toward satisfying the out-of-network deductible and vice-versa? — Larry

Yes. The deductible is the amount you pay before your health plan pays for medical services. For 2012, the Aetna Medicare℠ Plan (PPO) annual in-network deductible is $140 and the out-of-network deductible is $280. Any costs incurred from an in-network provider that apply to your in-network deductible will also be applied to the out-of-network deductible. Conversely, costs incurred from a non-participating provider that are applied to the out-of-network deductible would also be credited toward satisfying your in-network deductible.

Health Plan Contribution Reduced for Medicare-eligible Retirees who Retired on or after July 1, 2007

Beginning January 1, 2012, for the majority of retirees who paid the 3% health care contribution and are enrolled in Medicare now pay half of that rate or 1.5% of either final average gross salary or final annual gross salary.

Final average salary = the highest average compensation received during any three non-overlapping periods of four consecutive quarters. It includes overtime, shift differential and other payments. Typically, it is the average of your last three years of compensation.

Final annual salary = base annual salary at the time of retirement. It does not include overtime, shift differential, etc.

If you retired on or after July 1, 2007 through June 30, 2011 and you are Medicare eligible: Your contribution rate is reduced from 3% to 1.5% of your final average salary or final annual gross salary, whichever applies.

If you retired on or after July 1, 2011 and you are Medicare eligible: Your contribution rate is reduced from 3% to 1.5% of your final average salary.

If, because of your collective bargaining agreement, you currently have a rate of less than 3%, you will not be eligible for a reduction upon enrolling in Medicare. For employees in unions that have not agreed to this provision, the current collective bargaining agreement language for that union will apply until such time as new agreements are reached.

Here are some questions you may have about the lower contribution:

I'm enrolled in Medicare. Why didn't I see a reduction in my contribution?

The commonwealth and the unions had a tentative agreement in June 2011, but did not reach an agreement on specific language until January 19, 2012. SERS has begun the necessary changes.

Will I be reimbursed the extra 1.5% that was taken from my pension checks?

Yes, the extra amount will be offset in future pension payments.

What if I turn 65 in the middle of the month. When does my reduction occur?

Medicare enrollment generally would be the first of the same month you turn 65, therefore, your reduction would occur with the pension payment you receive at the end of that same month.

What if my spouse is enrolled in Medicare, but I am not. Do I still get the reduction?

No, the reduction does not apply until the retiree becomes enrolled in Medicare.

PEBTF

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Local: 717-561-4750
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PEBTF telephone hours:
8 a.m. – 5 p.m. Tuesday - Friday
8 a.m. – 6 p.m. Monday (or 1st day following a holiday weekend)

PEBTF Benefit News is available in an alternative format. Please contact the PEBTF to discuss your needs.

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IMPORTANT BENEFIT INFORMATION

Annual Notification

Important Information About the Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. The PEBTF health plans already complied with this important legislation requiring health plans to cover:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Coverage may be subject to deductibles and coinsurance, as detailed in your specific plan option.