January 1 – December 31, 2012

Evidence of Coverage:

Your Medicare Prescription Drug Coverage

This booklet gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2012. It explains how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013.

Express Scripts Insurance Company Customer Service:
For help or information, please call Customer Service at the number on the back of your ID card.
TTY users call: 1-800-899-2114
Hours of Operation: Representatives are available 24 hours a day, seven days a week

This plan is offered by Express Scripts Insurance Company Prescription Drug Plan (Employer PDP), referred throughout the Evidence of Coverage as "we," "us," "our," "Plan," "your Plan," or "our Plan."

Express Scripts Prescription Drug Plan is a standalone prescription drug plan with a Medicare contract. All beneficiaries must use their plan sponsor's network pharmacies to access their prescription drug benefit, except under non-routine circumstances. Quantity limitations and restrictions may apply. This information is available in alternate formats or languages. Please contact Customer Service at the number listed on the back of your ID card for additional information.

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Chapter 1: Introduction

Using This Booklet

This Evidence of Coverage booklet tells you how to get your Medicare prescription drug coverage through our Plan, a Medicare prescription drug plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the Plan.

This Plan is offered through your employer by Express Scripts Insurance Company Prescription Drug Plan (Employer PDP), referred throughout the Evidence of Coverage as "we," "us," or "our," "Plan," "your Plan," or "our Plan."

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of Express Scripts Insurance Company Prescription Drug Plan (Employer PDP).

This is a Contract

This Evidence of Coverage is part of our contract with you. Other parts of this contract include the Drug List (Formulary*)* and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in our plan between January 1 and December 31, 2012.

Medicare (the Centers for Medicare & Medicaid Services) must approve our Plan each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

Who Can be a Member?

You are eligible for membership in our Plan as long as:

- You live in our geographic service area - the U.S. and its territories. If you plan to move out of the service area, please contact Customer Service.
- You are entitled to Medicare Part A or you are enrolled in Medicare Part B (or you have both Part A and Part B).

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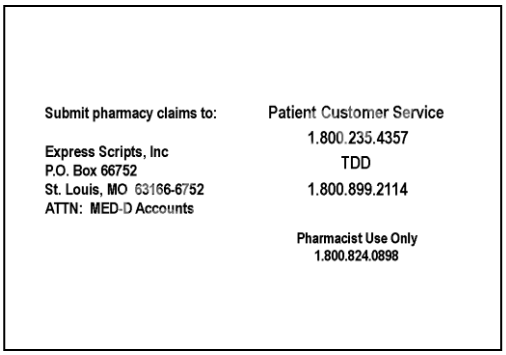
Your Membership ID Card

While you are a member of our Plan, you must use your plan membership card for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Updating Your Record

Please keep your membership record up-to-date. The pharmacists in the Plan's network need to have correct information about you. These network providers use your membership record to know what drugs are covered for you.

Call Customer Service to let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

Call Customer Service to Tell Us about Other Coverage
Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service.

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Protecting Your Personal Health Information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws. For more information on how we protect your personal health information, please go to Chapter 10.

How Other Insurance Works with Our Plan

When you have other insurance there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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Chapter 2: Important Phone Numbers and Resources

Plan Contacts

For assistance with claims, member card questions, or questions about your benefit, please contact Customer Service at the number located on the Quick Reference Guide, included with this packet, or on the back of your ID card. We will be happy to help you. For assistance with coverage decisions, appeals, and complaints, refer to the tables below for the correct contact information.

Express Scripts Contact Information for Coverage Decisions A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs.	
CALL	**1-800-417-8164** Available 24 hours a day, 7 days a week Calls to this number are free.
TTY	**1-800-899-2114** Available 24 hours a day, 7 days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	**1-877-837-5922**
WRITE	Express Scripts, Inc. Prior Authorizations - Part D Mail Route B401-03 8640 Evans Road St. Louis, MO 63134

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Express Scripts Contact Information for Appeals An appeal is a formal way of asking us to review and change a coverage decision we have made.	
CALL	**1-800-344-3405 ext. 373022** Available 7:00 a.m. to 8:00 p.m. (CST) Monday through Friday Calls to this number are free.
TTY	**1-800-899-2114** Available 7:00 a.m. to 8:00 p.m. (CST) Monday through Friday This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	**1-877-852-4070**
WRITE	Express Scripts, Inc. Pharmacy Appeals - Part D Mail Route BL0390 6625 West 78th Street Bloomington, MN 55439

Express Scripts Contact Information for Filing a Complaint You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.)	
CALL	**1-866-533-8512** Available from 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday Calls to this number are free.
TTY	**1-800-899-2114** Available from 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-305-1686
WRITE	Express Scripts, Inc. Grievance Department P.O. Box 66517 St. Louis, MO 63166

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Express Scripts Contact Information for Payment Requests Use this information for situations in which you may need to ask the plan for reimbursement.	
WRITE	Express Scripts, Inc. ATTN: Med-D Accounts P.O. Box 66752 St. Louis, MO 63166

Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

You can contact Medicare to:

- Ask questions.
- Download booklets.
- Get useful phone numbers and websites.
- Learn about Medicare drug plans.

CALL	**1-800-MEDICARE, or 1-800-633-4227** 24 hours a day, 7 days a week Calls to this number are free
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. These programs are independent, not connected with any insurance company or health plan. Counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, help you straighten out problems with your Medicare bills, and also help you understand your Medicare plan choices and answer questions about switching plans.

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For information on how to contact a SHIP in your state, call Medicare at 1-800-MEDICARE (1-800-633-4227). If you have trouble hearing, use the TTY line: 1-877-486-2048. You can call 24 hours a day, 7 days a week. You can also use the Medicare website at www.medicare.gov. Choose "Useful Phone Numbers and Websites" under "Help and Support."

Quality Improvement Organization

There is a Quality Improvement Organization for each state. These organizations have a group of doctors and other healthcare professionals, paid by the federal government, to check on and help improve the quality of care for people with Medicare. These are independent organizations, not connected with our plan. You should contact a Quality Improvement Organization if you have a complaint about the quality of care you have received.

For information on how to contact your QIO, call Medicare at 1-800-MEDICARE (1-800-633-4227). If you have trouble hearing, use the TTY line: 1-877-486-2048. You can call 24 hours a day, 7 days a week. You can also use the Medicare website at www.medicare.gov. Choose "Useful Phone Numbers and Websites" under "Help and Support."

Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare and pay the Part B premium. To apply for Medicare, you can call Social Security or visit your local Social Security office.

CALL	**1-800-772-1213** Available 7:00 a.m. to 7:00 p.m., Monday through Friday Calls to this number are free. You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** Available 7:00 a.m. to 7:00 p.m. (EST), Monday through Friday Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	http://www.ssa.gov

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Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

For information on how to contact Medicaid, call Medicare at 1-800-MEDICARE (1-800-633-4227). If you have trouble hearing, use the TTY line: 1-877-486-2048. You can call 24 hours a day, 7 days a week. You can also use the Medicare website at www.medicare.gov. Choose "Useful Phone Numbers and Websites" under "Help and Support."

Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

CALL	**1-877-772-5772** Available 9:00 a.m. to 3:30 p.m., Monday through Friday Calls to this number are free. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are ***not*** free.
WEBSITE	http://www.rrb.gov

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Chapter 3: Using This Plan to Buy Part D Drugs

This chapter explains rules for using your coverage for Part D drugs. In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. To find out more about this coverage, see your *Medicare & You* Handbook.

Basic Rules for the Plan's Part D drug Coverage

The Plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription.
- Your drug must be on our *List of Covered Drugs* (Formulary).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Using Network Pharmacies

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. Network pharmacies have a contract with us to provide your covered drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

How to Find a Network Pharmacy

To find a network pharmacy, call Customer Service at the number located on the back of your ID card, or check the pharmacy directory.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

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What if Your Pharmacy is Not in Our Network?
If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, please call Customer Service.

Specialized Pharmacies

Sometimes prescriptions must be filled at a specialized pharmacy. Our network includes these specialized pharmacies:

- Home Infusion Pharmacies
- Long-Term Care Facilities- Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Customer Services.
- Indian Health Service (IHS)/Indian Tribe and Tribal Urban Organization and Urban Indian Organization (I/T/U) Pharmacies. Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

For more information or to locate a specialized pharmacy, contact Customer Service or look in the pharmacy directory.

Mail-Order Pharmacy Services

For certain kinds of drugs, you can use our mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. Our Plan's mail-order service allows you to order up to a 90-day supply, which saves you money.

To get information about filling your prescriptions by mail, to see if your drugs qualify, and to request order forms, please call Customer Service at the number located on the back of your ID card. If you use a mail-order pharmacy not in the Plan's network, your prescription will not be covered.

It may take up to 14 days to get your order. If your order takes longer, our staff may call you to tell you about the delay. If you have questions about your order, call Customer Service at the number on the back of your ID card.

How to Get a Long-Term Supply of Your Drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Express Scripts offers two ways to get a long-term supply of maintenance drugs on our Plan's Drug List:

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- Through mail-order services
- Through some retail pharmacies. To find out which pharmacies offer a 90-day supply, call Customer Service at the number located on the back of your ID card.

Using an Out-of-Network Pharmacy

Generally, we cover drugs filled at an out-of-network pharmacy **only** when you are not able to use a network pharmacy. If you use a drugstore that is **not** in our network, you may need to pay the full cost of your drugs. You can ask us to reimburse you for our share of the cost.

Before using a non-network pharmacy, contact Customer Service at the number on the back of your ID card to see if there is a network pharmacy nearby.

You can use an out-of-network drugstore to fill a given prescription up to 1 time per Plan year.

Use Your ID Card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for our share of your covered prescription drug cost. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

Your prescription ID card includes all of the information needed by the pharmacy to process your prescription under this plan. Please ensure you present your ID card at the pharmacy each time you fill a prescription.

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the Plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to reimburse you for our share.

Covered Drugs (Formulary)

Our Plan has a *List of Covered Drugs*, also known as the Formulary or Drug List, which lists the drugs we cover**.** The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists, and must meet requirements set by Medicare. Medicare has approved the Plan's Drug List.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

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- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand name and generic drugs**.** A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug, but it usually costs less. There are generic-drug substitutes available for many brand name drugs.

Cost-Sharing Tiers

Every drug on the Plan's Drug List is in a cost-sharing tier. In general the higher the cost-sharing tier, the higher your cost for the drug. To find out which cost-sharing tier your drug is in, look it up on the Drug List or contact Customer Service at the number located on the back of your ID card.

Rules, Restrictions, and Limits

For certain prescription drugs, special rules restrict how and when the Plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

Our Plan uses different types of restrictions to help our members use drugs in the most effective ways. In general, our rules encourage you to get a drug that works for your medical condition and is safe. The Plan's rules are designed to encourage you and your doctor or other prescriber to use a lower-cost option that, medically, works just as well as a higher-cost drug, when available. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing. The sections below tell you more about the types of restrictions we use for certain drugs.

Generic Substitution

Generally, a "generic" drug works the same as a brand name drug, but usually costs less. When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version. However, if your doctor has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, and we approve, we will cover the brand name drug. Your share of the cost may be greater for the brand name drug than for the generic drug.

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Prior Authorization
For certain drugs, you or your doctor need to get approval from the Plan before we will agree to cover the drug for you. This is called "Prior Authorization." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the Plan.

Step Therapy
This requirement encourages you to try less costly but just as effective drugs before the Plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the Plan may require you to try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B. This requirement to try a different drug first is called "Step Therapy."

Quantity Limits
For certain drugs, we limit the amount of the drug that you can have. We may limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you.

Are Your Drugs Covered? Are There Restrictions?

Our Plan's Drug List includes information about which drugs are covered and the restrictions described above. The included Drug List contains information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. To find out if your drugs are covered or if any of these restrictions apply to a drug you take or want to take, check the most recent Drug List (included with this document) or contact Customer Service at the number located on the back of your ID card

What if your drugs are not covered in the way you'd like?

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** Some of the drugs covered by the plan have extra rules to restrict their use.

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For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug is covered during a particular time period.

- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of the different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not covered or has restrictions, here is what you can do:

You may be able to get a temporary supply.
Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do. To be eligible for a temporary supply, you must meet the two requirements below:

1. **The change to your drug coverage must be one of the following types of changes:**
   a. The drug you have been taking is no longer on the plan's Drug List.
   OR
   b. The drug you have been taking is now restricted in some way

2. **You must be in one of the situations described below:**
   a. **For those members who are new to the plan and aren't in a long-term care facility** we will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for at least a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
   b. **For those who are new to the plan and reside in a long-term care facility** we will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for at least a 31-day supply or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan, up to a 98-day supply.
   c. For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away we will cover one 31-day supply or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.
   d. For current beneficiaries who are affected by plan changes across contract years we will cover a temporary supply of your drug **one time only during the first 90 days** of the plan year. This temporary supply will be for at least a 30-day supply or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

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During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug.
Start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can file an exception.
You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 8 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

If your drug is in a cost sharing tier you think is too high, here are things you can do:

You can change to another drug.
Start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can file an exception.
You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 8 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Changes to the Drug List

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, we may make changes to the Drug List. Sometimes new drugs become available, a drug gets recalled, or we might remove a drug from the list because it has been found to be ineffective. We may:

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- Add or remove drugs from the Drug List.
- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug.
- Replace a brand name drug with a generic drug.

In almost all cases, we must get approval from Medicare for changes we make to the Plan's Drug List.

If there is a change to coverage for a drug you are taking, the Plan will send you a notice. Normally, we will let you know at least 60 days ahead of time.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year, if you stay in the Plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List for reasons other than a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days notice or give you a 60-day refill of your brand name drug at a network pharmacy. During this 60 -day period, you should be working with your provider to switch to the generic or to a different drug that we cover or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception see Chapter 8.
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

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Drugs Not on the Drug List

This Plan may not cover all prescription drugs. In some cases, the law does not allow any Medicare plan to cover certain types of drugs. In other cases, we have decided not to include a particular drug on our Drug List. This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not consider these Medicare Part D eligible drugs.

If you get drugs that are excluded, you may have to pay for them yourself. The only exception will be if the requested drug is found, upon appeal, to be a drug that is not excluded under Part D and we should have paid for or covered because of your specific situation.

Your coverage may include additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. For information on what drugs are covered under your plan, refer to the Drug List or call Customer Service. Here are three general rules about drugs that are not covered under Medicare Part D:

- If the drug would be covered under Medicare Part A or Part B.
- If the drug was purchased outside the United States and its territories.
- If the drug is prescribed for off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered unless your benefit includes enhanced drug coverage:

- Nonprescription drugs (over-the-counter)
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

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If you are receiving "Extra Help" from Medicare to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

Part D Drug Coverage in Special Situations

If You Have a Hospital Stay

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our Plan will cover your drugs as long as the drugs meet all of our rules for coverage, or they have been approved through an exception or appeal.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility and Part A is no longer covering your drugs, our Plan will cover your drugs as long as they meet all of our rules for coverage or they have been approved through an exception or appeal.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time.

If You are a Resident in a Long-Term Care (LTC) Facility

Usually, a long-term care facility (such as a nursing home) has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network. Call Customer Service to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, call Customer Service.

If You are Taking Drugs Covered by Original Medicare

Your enrollment in this plan does not affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

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If You Have Drug Coverage from another Source

If you have other prescription drug coverage, please contact your former employer's benefits administrator. They can help you determine how that prescription drug coverage will work with our Plan.

Programs to Help Manage Your Drugs and Drug Costs

Drug Use Review

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs. We do a review each time you fill a prescription to look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Medication Therapy Management

If you have several complex medical conditions, take many drugs at the same time, and have high drug costs, you may qualify for our **Medication Therapy Management (MTM)** program. This program has been developed by our team of pharmacists and doctors. The program helps to make sure you are using the drugs that work best to treat your medical conditions and helps us to identify possible medication errors. The MTM program can also advise you on how to lower your drug costs and reduce side effects.

This is a free program. If you qualify, you will automatically be enrolled in our MTM program. We will send you more information on the program and tell you how to get started. If you decide not to participate, please notify us and we will withdraw you from the program.

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Chapter 4: Levels of Coverage

As shown in the table below, there are generally four "drug payment stages" for Part D prescription drug coverage. **Depending on your plan, all of these stages may not apply.** How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium (if applicable) regardless of the drug payment stage.

Please refer to your other plan documents to understand your benefit design and cost-sharing at each stage.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
You begin in this payment stage when you fill your first prescription of the year. During this stage you pay the **full cost** of your drugs. You stay in this stage until you have reached your deductible. ***This stage may not apply to all plans.***	The Plan pays its share of the cost of your drugs, and you pay your share of the cost. You stay in this stage until payments for the year reach the initial coverage limit of $2,930.	Your cost-sharing amount at this stage will depend on your benefit design. You stay in this stage until your "out-of-pocket costs" reach a total of $4,700. This amount and rules for counting costs toward this amount have been set by Medicare.	Once you have paid enough for your drugs to move on to this last payment stage, the Plan will pay most of the cost of your drugs for the rest of the year.

As shown in this summary of the payment stages, whether you move on to the next payment stage depends on how much you and/or the Plan spend for your drugs while you are in each stage.

Calculating Your Drug Costs

Moving from one stage of the plan to the next is based on your drug costs. We keep track of two different drug cost amounts; total drug spend (TDS) and true out-of-pocket (TrOOP). In this section you will find a description about what costs count towards each of these amounts.

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Total Drug Spend (TDS)

Total drug spend includes the amount you paid out-of-pocket and the amount your plan has paid. Costs paid by others on your behalf may also be included.

True Out-of-Pocket (TrOOP)

Medicare has rules about what counts towards your out-of-pocket costs, also known as your true out-of-pocket or TrOOP. Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

Payments that **are** included in your out-of-pocket costs:

- Any amount you paid for eligible Part D drugs while in the deductible, initial coverage, and coverage gap stages.
- Any payment you made during the plan year under another Medicare prescription-drug plan before you joined our Plan.
- Payments made on your behalf, by others, or certain organizations. This includes family, friends, most charities, AIDS drug assistance programs, the Indian Health Service, a state pharmaceutical assistance program that is qualified by Medicare, payments made by Medicare's "Extra Help", and the Medicare Coverage Gap Discount Program.

Payments that **are not** included in your out-of-pocket costs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our Plan.
- Drugs you get at an out-of-network pharmacy that do not meet the Plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs that may be covered under additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Note: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our Plan. Call Customer Service to let us know.

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The Deductible Stage

The Deductible Stage may not apply to your plan. Refer to your other plan documents, included with this document, to determine if your plan has a deductible.

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, you must pay the full cost of your drugs until you reach the Plan's deductible amount.

- Your **"full cost"** is usually lower than the normal full price of the drug, since our Plan has negotiated lower costs for most drugs.
- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have reached the deductible amount, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

The Initial Coverage Stage

During the Initial Coverage Stage, the Plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription. During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$2,930 limit for the Initial Coverage Stage.**

Your total drug cost is based on adding together what you have paid and what the plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage.

Your plan may offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs.

The *Explanation of Benefits* that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the initial coverage

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limit in a year. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

Refer to your other plan documents for your cost-sharing amount while in the Initial Coverage Stage.

The Coverage Gap Stage

This plan does include a Coverage Gap Stage; however your co-pays while in the coverage gap will remain the same as during the Initial Coverage Stage. The plan continues to cover your drugs at your regular cost-sharing amount until you qualify for the Catastrophic Coverage Stage.

For 2012, your benefit will be made up of two plans; a primary Part D plan and a secondary supplemental plan for the Coverage Gap Stage only. The pharmacy will only need to submit your prescription once to the Primary Part D portion of your plan. During the coverage gap stage, if your prescription is identified as an applicable drug, typically brand name drugs, the prescription will automatically process under the secondary supplemental coverage. This ensures the correct co-pay is applied to your prescription in all stages of the benefit.

All of the information needed to process your prescription is included on your prescription ID card. You should present your ID card each time you fill a prescription to ensure your coverage is applied correctly.

This benefit design does not apply if you are receiving Extra Help from Medicare. For more information on the Medicare Coverage Gap Discount Program and applicable drugs, please read the Chapter 6 section titled "Medicare Coverage Gap Discount Program."

You will remain in the Coverage Gap Stage until your yearly true out-of-pocket (TrOOP) payments reach a maximum amount that Medicare has set. In 2012, that amount is $4,700. If you reach this limit, you leave the Coverage Gap and move on to the Catastrophic Coverage Stage.
Refer to your other plan documents for your cost-sharing amount while in the Coverage Gap.

The Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your true out-of-pocket costs have reached the $4,700 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, the plan will pay most of the cost for your drugs.

Refer to your other plan documents for your cost-sharing amount in the Catastrophic Stage.

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Tracking Your Out-of-Pocket Costs and Total Drug Costs

Our Plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- **True out-of-pocket costs (TrOOP)** - amount paid by you or others on your behalf.
- **Total drug spend (TDS)** - amount paid by you or what others pay on your behalf plus the amount paid by the Plan.

Our Plan will prepare a written monthly report called the Explanation of Benefits (EOB) when you have had one or more prescriptions filled. It includes:

- **Information for that month** including payment details about the prescriptions you have filled during the previous month, total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Keeping Your Drug Costs Up-to-Date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up-to-date:

- **Show your membership card when you get a prescription filled.** Your prescription ID card includes all of the information needed for the pharmacy to process your prescription. To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased For example, when you purchase a drug using a discount card outside of our Plan or through a patient assistance program through a drug manufacturer, or any time you purchase covered drugs at out-of-network pharmacies, or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** If you receive an Explanation of Benefits in the mail each month, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or if you have any questions, please contact Customer Service at the number located on the back of your ID card. Be sure to keep these reports. They are an important record of your drug expenses.

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Chapter 5: Your Costs

Your Premium

Your coverage is provided through a contract with your current employer or former employer or union. As a member of our Plan, you ***might*** pay a monthly plan premium. This is the amount you must pay each month to stay in the plan offered by your former employer. For information on what you will pay each month for your prescription drug coverage, refer to your other plan documents, or contact your former employer at the number located on the Quick Reference Guide included in this packet.

We are not allowed to change the amount charged for the Plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in advance, and the change will take effect on January 1.

If you are enrolled or qualify for a state pharmaceutical assistance program or "Extra Help" through Medicare, these programs might lower your monthly plan premium.

Other Medicare Premiums
Some plan members will be paying a premium for Medicare Part A, and most plan members will be paying a premium for Medicare Part B, in addition to paying the monthly plan premium. Keep paying your premium for Medicare Part A or B if you have been paying it or were paying it when you joined.

Late Enrollment Penalty

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

The penalty is added to your monthly premium. When you first enroll in our plan, we will let you know the amount of the penalty. Your late enrollment penalty is considered to be part of your plan premium. If you do not pay the part of your premium that is the late enrollment penalty you could be disenrolled for failure to pay your plan premium.

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Determining Your Late Enrollment Penalty

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year.
- To get your monthly penalty, multiply the penalty percentage and the average monthly premium and round it to the nearest 10 cents. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

There are three important things to note about this monthly premium penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage from another source - coverage that was at least as good as a Part D drug plan.
    - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
    - For additional information about creditable coverage, please look in your *Medicare & You* 2012 Handbook or call Medicare at 1-800-MEDICARE

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(1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

If You Disagree with the Late Enrollment Penalty

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Service to find out more about how to do this.

Income Based Payments

Some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage.

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Your Copayment or Coinsurance

When you fill a prescription for a covered drug, you may pay part of the cost. This is your copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

The amount you pay for your drug depends on:

- What level of coverage you are in.

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- Whether you are buying the drug at an in-network or out-of-network drugstore.
- The type of drug you are buying and what tier it is in.

Refer to your other plan documents for your cost-sharing amounts.

Vaccination Costs

Our Plan provides coverage for a number of vaccines covered under Part D. There are two parts to our coverage of vaccinations:

- **Cost of the vaccine medication itself**. The vaccine is a prescription medication.
- **Cost of giving you the vaccination shot**. This is sometimes called the "administration" of the vaccine.

What you pay for a Part D vaccination depends on:
1. What level of coverage you are in.
2. Where you get the vaccine medication.
3. Who gives you the vaccination.

If you are in the deductible stage(if applicable) you will pay the full cost for the vaccine and the administration.

If you are in the initial coverage stage, what you pay at the time you get the vaccination can vary depending on the circumstances. To show how this works, here are three common ways you might get a vaccination shot.

Situation 1: You buy the vaccine at a network pharmacy, and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay your copayment or coinsurance amount for the vaccine and administration of the vaccine.

Situation 2: You get the vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our Plan to pay our share of the cost.
- You will be reimbursed the amount you paid less your normal coinsurance *or* copayment for the vaccine and the difference between the amount the doctor charges and what we normally pay.

Situation 3: You buy the vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

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- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost. You can then ask our Plan to pay our share of the cost.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less the difference between the amount the doctor charges and what we normally pay.

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us at Customer Service at the number located on the back of your ID card, if you have any questions.

We can tell you about how your vaccination is covered by our plan and explain your share of the cost, and how to keep your own cost down by using providers and pharmacies in our network. If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

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Chapter 6: Help with Drug Costs

There are a number of programs that help people who qualify pay their drug costs. Described below are some of these programs.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. Extra help counts towards your out-of -pocket costs, and will help you pay for your:

- Premium (if applicable).
- Deductible (if applicable).
- Copayments or coinsurance.

Do You Qualify for Extra Help?
Some people automatically qualify for Extra Help and don't need to apply. You will receive a letter if you automatically qualify.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office.

Is Your Copayment Too High?
If you believe you have qualified for "Extra Help" and your copayment is too high or you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, please call Customer Service at the number located on the back of your ID card.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy and reimburse you if necessary.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on applicable drugs, typically brand name drugs, to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount. This discount will be provided to the

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plan on your behalf to help pay for drug costs. While in the Coverage Gap, you will pay the same amount for your prescription drugs as you did during the Initial Coverage Stage.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount provided. This amount will appear on your Explanation of Benefits (EOB) under other payments as "Medicare Coverage Gap Discount Program." Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs and move you through the coverage gap.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?
If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. The 50% discount is applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?
No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount and you think you should have?
If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next Explanation of Benefits (EOB) notice. If the discount doesn't appear on your Explanation of Benefits (EOB), you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Program

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members. These programs may go by SPAP (State Pharmaceutical Assistance Program), or may have a different name.

If you qualify, you may get help paying your:
- Deductible (if applicable).
- Premium (if applicable).

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- Copayment or coinsurance.

Contact the SPAP office in your state to learn more. To find information on how to reach your SPAP, call Medicare at 1-800-MEDICARE (1-800-633-4227). If you have trouble hearing, call the TTY line at 1-877-486-2048. You can call 24 hours a day, 7 days a week.

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Chapter 7: Requesting Reimbursement from the Plan

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our Plan to pay you back (paying you back is often called "reimbursing" you). Following are some examples of when you should ask the Plan to pay you back:

- **When you use an out-of-network pharmacy to get a prescription filled**. If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.
- **When you pay the full cost for a prescription because you don't have your plan membership card with you**. If you do not have your plan membership card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the Plan to get your member information, but there may be times when you may need to pay if you do not have your card.
- **When you pay the full cost for a prescription in other situations**. You may pay the full cost of the prescription because you find that the drug is not covered for some reason. For example, the drug may not be on the Plan's Drug List (Formulary), or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it. We may need to contact your doctor for more information in order to pay you back.
- **If you are retroactively enrolled in our plan**. Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs

For situations such as these, save your receipts and send copies to us when you ask us to pay you back. All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision.

Submit the Request for Payment

To make sure you are giving us all the information we need, you can fill out our claim form to make your request for payment. Call Customer Service at the number located on the back of your ID card, and ask for the form. Send us your request along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

If you already have a form, refer to the Quick Reference Guide included with this document or Chapter 2 of this document for the mailing address you can use to request reimbursement.

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Please be sure to contact Customer Service if you have any questions. If you don't know what you owe, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

We Consider Your Request

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you.

If we decide that the drug is not covered or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

If you think we have made a mistake in turning you down, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For more details on the coverage determination process and how to make this appeal, please read Chapter 8.

Other Situations When You Should Notify Us of Your Out-of-Pocket Costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

- **When you buy the drug for a price that is lower than our price**. When you are in the Deductible Stage (if applicable) you may be able to buy your drug **at a network pharmacy** for a price that is lower than our price. A pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price. Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.

  Please note: If you are in the Deductible Stage we will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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- **When you get a drug through a patient assistance program offered by a drug manufacturer.** Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

  Please note: Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

For both of these situations, you should save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage. Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

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Chapter 8: Coverage Decisions and Appeals

There is a process for requesting coverage decisions and making appeals related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered. This process has been approved by Medicare. To ensure fairness and prompt handling of your problems, this process has a set of rules, procedures, and deadlines that must be followed by us and by you.

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in the Coverage Determination and Appeals chapter as well as the following Grievance chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, we explain the legal rules and procedures using more common words in place of certain legal terms. For example, we generally say "making a complaint" rather than "filing a grievance," "coverage decision" rather than "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." We also use abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

Asking for a Coverage Decision
A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an Appeal
If we make a coverage decision and you are not satisfied with this decision, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not

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satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Who Can Request a Coverage Decision or Appeal?
You can make the request yourself, or you can have someone act on your behalf. Your doctor or other provider can request a coverage decision or a Level 1 appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.

If you prefer, you can name another person to act for you as your representative to ask for a coverage decision or to make an appeal. If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf) This form gives that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our Plan a copy of the signed form.

You also have the right to hire a lawyer to act for you. There are groups that will give you free legal services, if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or to appeal a decision.

How to Get Help with Requesting a Coverage Determination or Appeal
Sometimes it can be confusing to start or follow through the process for dealing with a problem. You may not have the knowledge you need to take the next step. For additional help, here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal:

- You **can call us at Customer Service** at the phone number on the back of your ID card.
- You can get help from an independent government organization. If you want help or guidance from someone who is not connected to us, you can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do. The services of SHIP counselors are free. For help contacting a SHIP in your state, please contact Medicare.
- You can also get help and information from **Medicare**. You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or, you can visit the Medicare website at http://www.medicare.gov.

Requests You Might Make

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. The **legal term** for an initial coverage decision about your Part D

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drugs is called a **"coverage determination."** Here are examples of coverage decisions you might ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the Drug List
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the Drug List but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

Requesting an Exception

If a drug is not covered in the way you would like it to be covered, you can ask the Plan to make an exception. **An exception is a type of coverage decision**. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

- **Covering a Part D drug for you that is not on our plan's Drug List** (The **legal term** for this is also known as a **formulary exception**)**.** If we agree to make an exception and cover a drug that is not on the Drug List you will need to pay the cost-sharing amount that applies. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- **Removing a restriction on the plan's coverage for a covered drug** (The **legal term** for this is also known as a **formulary exception**.) There are extra rules or restrictions that apply to certain drugs on the Plan's Drug List. If our plan agrees to make an exception and waives a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug. For more information on restrictions see "Rules, Restrictions, and Limits" section under the "Covered Drugs" section in Chapter 3.
- **Changing coverage of a drug to a lower cost-sharing tier** (The **legal term** for this is also known as a **tiering exception.)** If your drug is in a higher tier, you can ask us to cover the drug at the cost-sharing amount that applies to drugs in a lower tier. This would lower your share of the cost for the drug.

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Important Things to Know About Asking for Exceptions

- Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.
- Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.
- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal.

The next section tells you how to ask for a coverage decision, including an exception.

How to Request a Coverage Decision

Step 1: Ask Our Plan to Make a Coverage Decision

Request the type of coverage decision you want. Start by calling, writing, or faxing our Plan to make your request. For coverage decision and appeals contact information, refer to the **Plan Contacts** section in Chapter 2.

If you are requesting an exception, provide the doctor's statement. Your doctor or other prescriber can fax or mail the statement to our Plan. Your doctor or other prescriber can also tell us on the phone and follow up by faxing or mailing the signed statement.

Note: If you want to ask our Plan to pay you back for a drug, refer to Chapter 7 which describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

Step 2: We Consider Your Request and Give You an Answer

We must give you our answer **within 72 hours** of the receipt of your request if you have not yet received the drug**.** If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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If you are asking for reimbursement for a drug you already bought, we must give you our answer **within 14 calendar days** after we receive your request.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you **within 30 calendar days** after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

If we do not give you a decision within the deadlines for either of these scenarios, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization.

Step 3: If We Say No, You Decide if You Want to Make an Appeal

If our Plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made. To start the appeal process, see the section titled "Making a Level 1 Appeal."

Requesting a Fast Decision

If your health requires a quick response, you must ask us to make a "**fast decision**" when requesting a coverage decision. The legal term for this is called an **expedited coverage determination**. To get a fast decision, you must meet two requirements:

- You must be asking for a drug you have not yet received.
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.

If your doctor or other prescriber tells us that your health requires a fast decision, we will automatically agree to give you a fast decision.

If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our Plan will decide whether your health requires that we give you a fast decision. If we decide that your health problem does not meet our rules for a fast decision, we will send you a letter. The letter will tell you:

- How to file a fast complaint if you think we should have given you a fast decision.
- That if you get a doctor's support, we will give you a fast decision.
- That we will give you a standard decision.

How Long Will a Fast Decision Take?

If we are using the fast deadlines, we must give you our answer **within 24 hours**. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization.

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- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide **within 24 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

Making a Level 1 Appeal

If we do not decide fully in your favor on a coverage decision, you can ask us to review all or part of our determination. This review is called an appeal to the Plan. The legal term for an appeal to the plan about a coverage decision is called a **redetermination**. We will give your appeal request to people who were not involved in the coverage determination.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

Step 1: Contact Our Plan to Make an Appeal

To start your appeal, you must contact our Plan. For coverage decision and appeals contact information, refer to the **Plan Contacts** section in Chapter 2.

If you are asking for a standard appeal, make your appeal by submitting a written request.

If you are asking for a **fast appeal**, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2. The requirements for getting a fast appeal are the same as those for getting a fast decision (see previous section **Requesting a Fast Decision**). The **legal term** for a fast appeal is an **"expedited redetermination**."

You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you. If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Step 2: We Consider Your Appeal and Give You an Answer

When our Plan is reviewing your appeal, we check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

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Deadlines for a Standard Level 1 Appeal

If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. If you believe your health requires it, you should ask for "fast" appeal.

If our answer is yes to part or all of what you requested – we must provide the coverage we have agreed to as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.

- If we approve a request to pay you back for a drug you already bought, we are required to send payment to you **within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a Fast Level 1 Appeal

If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

If we do not give you a decision within the deadlines for a standard or fast appeal, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization.

Step 3: You Decide if You Want to Make another Appeal

If our Plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Making a Level 2 Appeal

If our Plan says no to your Level 1 Appeal, you can choose to go on to a Level 2 Appeal, where the **Independent Review Organization** reviews the decision our Plan made when we said no to your first appeal. The formal name for the Independent Review Organization is the **Independent Review Entity**, sometimes called the **IRE**.

The Independent Review Organization is an outside, independent organization that is hired by Medicare. This organization is not connected with our Plan, and it is not a government agency. This organization is a company chosen by Medicare to review our decisions and decide whether the decision we made should be changed.

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Step 1: Contact the Independent Review Organization

If our Plan says no to your Level 1 Appeal, the written notice we send you will include instructions on how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to request this information from us. For coverage decision and appeals contact information, refer to the **"Plan Contacts"** section in Chapter 2. You have the right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization Considers Your Appeal and Gives You an Answer

Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it. Deadlines and timing for a Level 2 Appeal are the same as Level 1.

If the Independent Review Organization says yes, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision for a fast appeal, and within 72 hours for a standard appeal. If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision.

If the Independent Review Organization says no to your appeal, it means the organization agrees with our decision not to approve your request.

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Step 3: You Decide if You Want to Make another Appeal

If the Independent Review Organization says no and your appeal meets the requirements, you can decide if you want to make another appeal. There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

The Level 3 Appeal is handled by an administrative law judge. For most situations that involve appeals, the last three levels of appeal work in much the same way. The next section in this chapter tells more about who handles Levels 3, 4, and 5 of the appeals process.

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Making a Level 3 Appeal

When making a Level 3 Appeal, a judge who works for the federal government will review your appeal and give you an answer. This judge is called an Administrative Law Judge.

If the Administrative Law Judge says yes to your appeal, the appeals process is over. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

If the Administrative Law Judge says no to your appeal, you can:

- Accept this decision that turns down your appeal, and the appeals process is over.
- Continue to the next level of the review process. If the Administrative Law Judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue.

Making a Level 4 Appeal

When making a Level 4 Appeal, the Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

If the Medicare Appeals Council says yes to your appeal, the appeals process is over. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

If the Medicare Appeals Council says no to your appeal, you can:

- Accept this decision that turns down your appeal, and the appeals process is over.
- Continue to the next level of the review process. If the Medicare Appeals Council says no or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal, and what to do next if you choose to continue with your appeal.

Making a Level 5 Appeal

When making a Level 5 Appeal, a judge at the Federal District Court will review your appeal. This is the last step of the appeals process.

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Chapter 9: Making a Complaint

This section explains how to use the process for making complaints. What this chapter calls a "complaint" is also known as a "grievance." Another term for "making a complaint" is "filing a grievance."

The complaint process is used for problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process. If you have any of these problems, you can file a complaint:

- Unhappy with the quality of your medical care
- Disrespect, poor customer service, or other negative behaviors
- Unhappy about how Customer Service has dealt with you
- Kept waiting too long by a pharmacist or Customer Service
- Unhappy with the cleanliness or condition of a pharmacy
- Believe the written information we have given you is too hard to understand
- Believe we have not given you the notice we are required to give
- Right to privacy was not respected

Reasons for possible complaints may also be related to the timeliness of our actions in respect to the coverage decisions and appeals process. If you have already asked for a coverage decision or made an appeal, and you think our Plan is not responding quickly enough, you can also make a complaint about our response time:

- You asked us to give you a 'fast response' and we have said we will not.
- You believe our Plan is not meeting the deadlines for giving you a coverage decision or answer to an appeal.
- You believe we are not meeting the deadlines for covering or reimbursing you for an approved coverage decision or appeal.
- Our Plan does not give you a decision on time, and fails to forward your case to the Independent Review Organization within the required time limit.

Who Can File a Complaint?
You can file a grievance yourself, or you can have someone act for you. If you want a friend, relative, your doctor, or other person to be your representative, call Customer Service and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.

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Making a Complaint

Step 1: Contact Our Plan to File a Complaint

Call our Plan at the number for filing a grievance listed under **Plan Contacts** in Chapter 2. If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. The complaint must be made **within 60 calendar days** after you had the problem you want to complain about.

If you are making a complaint because we denied your request for a **fast response** to a coverage decision or appeal, we will automatically give you a fast complaint. If you have a "fast" complaint, it means we will give you an answer **within 24 hours**. A "fast complaint" may also be referred to as an "expedited grievance."

Step 2: We Review Your Complaint and Give You an Answer

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. In some cases, you can get a fast grievance, and we will respond within 24 hours.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Quality of Care Complaints

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to our Plan). If you make a complaint to this organization, we will work with them to resolve your complaint.
- **You can make your complaint to our Plan and the Quality Improvement Organization at the same time**.

Refer to Chapter 2 for information on how to contact your Quality Improvement Organization.

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Chapter 10: Your Rights and Responsibilities

Your Rights

You have the right to receive information in a way that works for you.

To get information from us in a way that works for you, please call Customer Service at the number located on the back of your ID card. Our Plan has people and services available to answer questions from non-English speaking members.

If you have trouble getting facts about our Plan because of language or disability, call 1-800-MEDICARE (1-800-633-4227). If you have trouble hearing, use the TTY line: 1-877-486-2048. You can call 24 hours a day, 7 days a week.

You have the right to be treated with fairness and respect at all times.

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are on the cover of this booklet).

You have the right to get your covered drugs quickly.

As a member of our Plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapters 8 and 9 of this booklet tells what you can do.

You have the right to privacy of your personal health information.

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

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The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells about these rights and explains how we protect the privacy of your health information.

In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you. There are certain exceptions allowed or required by law that do not require us to get your written permission first. For example, we are required to release health information to government agencies that are checking on quality of care.

We are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You have the right to your medical records and to know how they are used.

You have the right to look at your medical records held at the Plan and to get a copy of your records. We are allowed to charge you a fee for these copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service at the number located on the back of your ID card.

You have the right to know about the Plan, your benefits, and covered drugs.

As a member of our Plan, you have the right to get several kinds of information from us. If you want any of the following kinds of information, please call Customer Service at the number located on the back of your ID card:

- **Information about our Plan**. This includes the Plan's financial condition and information about the number of appeals made by members.
- **Information about our network pharmacies.** For detailed information about our pharmacies, call Customer Service at the number located on the back of your ID card.
- **Information about your coverage and rules you must follow in using your coverage.** Chapter 3 along with the Drug List (Formulary) will tell you what drugs are covered and explain the rules you must follow. If you have questions, please call Customer Service.
- **Information about why something is not covered and what you can do about it.** If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can

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ask us for a written explanation. If you are not happy or disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 8 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision.

You have the right to make decisions about your care and use an advance directive.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. You can fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself. You can also give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for healthcare**" are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get a form from your lawyer, a social worker, or some office supply stores.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to the appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

It is your choice whether you want to fill out an advance directive. According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

If you have signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with your State Department of Health.

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You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, you have the right to ask our Plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do, we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service.

If You Think You are Being Treated Unfairly

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having by **calling Customer Service, the State Health Insurance Assistance Program,** or you can call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

To Learn More About Your Rights

There are several places where you can get more information about your rights:

- You can call Customer Service at the number located on the back of your ID card.
- You can call the State Health Insurance Assistance Program.
- You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
    - Go to the Medicare website http://www.medicare.gov to read or download the publication "Your Medicare Rights & Protections."

Your Responsibilities

Things you need to do as a member of the Plan are listed below. If you have any questions, please call Customer Service at the number located on the back of your ID card. We're here to help.

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Get familiar with your covered drugs and the rules you must follow to get these covered drugs. Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered drugs.

If you have any other prescription drug coverage in addition to our Plan, you are required to tell us. Please call Customer Service to let us know. We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it.

Tell your doctor and pharmacist that you are enrolled in our Plan. Show your plan membership card whenever you get your Part D prescription drugs.

Help your doctors and other providers help you by giving them information, asking questions, and following through on your care. Learn about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon. Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements. If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

Pay what you owe. As a Plan member you are responsible for paying your drug costs including your copayment or coinsurance and your premium (if applicable)**.** If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

Tell us if you move. If you are going to move, it is important to tell us right away. Contact Customer Service to update your contact information. If you move outside our service area - the US and its territories - you cannot remain a member of our Plan. If you move within our service area, we need to know so we can keep your contact information and membership record up to date.

Call Customer Service for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan. Phone numbers and calling hours for Customer Service are on the back of your ID card.

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Chapter 11: Ending Your Membership in the Plan

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice).

Leaving the Plan Voluntarily

If you would like to leave our Plan, contact your former employer at the number provided in the enclosed Quick Reference Guide. They will let you know how you can terminate your coverage.

Since you are a member of an employer sponsored plan, please check with the benefits administrator for your former employer or retiree group **before you change your plan**. This is important because **you may lose benefits you currently receive under your employer or retiree group coverage if you switch plans.**

When You Can Leave Our Plan

The best time to end your membership with our Plan is during the **Annual Enrollment Period**. This happens from October 15 to December 7 in 2011. This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year. Any changes you make will take effect January 1, 2012.

If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**. Your membership will usually end on the last day of the month after we receive your request to change your plan. If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period:

- You have moved out of your plan's service area.
- You have Medicaid.
- You are eligible for "Extra Help" with paying for your Medicare prescriptions.
- You live in a facility, such as a nursing home.
- You qualify under the terms of your former employer.

Keep Yourself Covered

If you leave our Plan, it is a good idea to switch to a plan with drug coverage that is at least as good as Medicare's. This is called "creditable coverage." If you go more than 63 days without creditable Part D coverage, Medicare may charge you a late enrollment fee when you enroll in another Part D plan. For more information, refer to the "Late Enrollment Penalty" Section in Chapter 5.

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Special note about creditable coverage:
Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable and describes the choices you have for drug coverage. If the coverage from the group plan is **creditable**, it means that it has drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.
Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

More Information on Ending Your Membership

If you have any questions or would like more information on when you can end your membership:

- Contact your benefits administrator for your former employer or retiree group.
- Contact Customer Service at the number located on the back of your ID card.
- Contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can find the information in the ***Medicare & You 2012*** Handbook sent to all Medicare members each year. You can also download a copy from the Medicare website http://www.medicare.gov, or call Medicare to request a printed copy.

Continue to Use our Plan until Your Membership has Ended

If you leave our Plan, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your prescription drugs through our Plan. Continue to use our network pharmacies to get your prescriptions filled until your membership in our Plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

Leaving the Plan Involuntarily

Our Plan must end your membership in the plan if any of the following happens:

- You do not stay continuously enrolled in Medicare Part A or Part B (or both).
- You move out of our service area.
- You become incarcerated.
- You lie about or withhold information about other insurance you have that provides prescription drug coverage.
- You intentionally give us incorrect information when you are enrolling in our Plan and that information affects your eligibility for our Plan.

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- You continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our Plan (with Medicare's permission).
- You let someone else use your membership card to get prescription drugs. (Medicare may have your case investigated by the Inspector General).
- You do not pay the plan premiums (if applicable and pursuant to your former employer).

If you think we have wrongfully ended your membership, you have a right to appeal our decision. For information about how to appeal the termination of coverage, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Your Health Cannot Be a Reason We Ask You to Leave

We cannot ask you to leave our Plan for any reason that involves your health. If you feel that you are being asked to leave our Plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

You Have the Right to Make a Complaint if We End Your Membership in our Plan

If we end your membership in our Plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership.

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Chapter 12: Legal Notices

SECTION 1 Notice About Governing Law

Many laws apply to this *Evidence of Coverage,* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply, and under certain circumstances, the laws of the state you live in.

SECTION 2 Notice About Nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

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Chapter 13: Definitions of Important Words

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Applicable Drug– A drug identified as eligible for the Medicare Coverage Gap Discount Program. Typically brand name drugs.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,700 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered, (2) any fixed copayment amount that a plan requires when a specific drug is received, or (3) any coinsurance amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the Drug List is in one of the cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription.

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Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

Creditable Prescription Drug Coverage – Prescription drug coverage that is expected to cover, on average, at least as much as Medicare's standard prescription drug coverage.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Deductible – The amount you must pay for prescriptions before our Plan begins to pay its share of your covered drugs.

Disenroll or **Disenrollment** – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Emergency – A medical emergency is when you believe that you have an injury or illness that requires immediate medical attention to prevent a disability or death.

Evidence of Coverage (EOC) and Disclosure Information – This document and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan's formulary (a formulary exception), or get a nonpreferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, generic drugs work the same as a brand name drug, but usually cost less.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

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Initial Coverage Stage – This is the stage after you have met your deductible (if applicable) before your total drug expenses have reached the initial coverage limit, including amounts you've paid and what our plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

List of Covered Drugs (Formulary or Drug List) – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy/"Extra Help" – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the federal government and certain drug manufacturers. For this reason, most, but not all brand name drugs are discounted.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

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"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare (Traditional Medicare or Fee-For-Service Medicare) – Original Medicare is offered by the government, and is not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital, or other healthcare provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

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Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets prior authorization from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other healthcare experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare providers.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you move out of the plan's service area.

Special Enrollment Period – A specific time when members can change their health or drugs plans or return to Original Medicare.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

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