January 1 – December 31, 2010

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of **Medco Medicare Prescription Plan®** (PDP) for Tennessee Valley Authority (TVA)

This booklet gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2010. It explains how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Medco Medicare Prescription Plan (PDP) Customer Service:

For help or information, please call Customer Service or go to our plan website at **www.medco.com**.

Calls to these numbers are free:

1-800-592-4520
TTY/TDD users call: **1-800-716-3231**

This plan is offered by Medco Containment Insurance Company of New York and Medco Containment Life Insurance Company referred throughout the Evidence of Coverage as "we," "us," or "our." **Medco Medicare Prescription Plan** (PDP) is referred to as "Plan" or "our Plan."

Medco Medicare Prescription Plan® (PDP) is a Medicare-approved Part D sponsor that is offered nationally in 35 Medicare regions, including the District of Columbia and Puerto Rico. This prescription drug plan is underwritten by Medco Containment Insurance Company of New York, an insurance company licensed in New York, and Medco Containment Life Insurance Company, an insurance company licensed or authorized to do business in the states that comprise the other 34 Medicare regions.

This information is available in a different format, including Spanish and braille. Please call Customer Service at the numbers listed above if you need plan information in another format or language.

Esta información es disponible en otros idiomas u otros formatos, incluyendo una versión en español y una versión en braille. Póngase en contacto con el departamento de Atención al cliente marcando los números que se indican arriba, si necesita recibir la información del plan en otro formato u otro idioma.

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SECTION 1 Introduction

Section 1.1 What is the Evidence of Coverage booklet about?

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

- You are covered by your former employer or union for your health care coverage, and they have chosen to get your Medicare prescription drug coverage through our Plan, **Medco Medicare Prescription Plan** (PDP).

This plan is offered by Medco Containment Life Insurance Company and Medco Containment Insurance Company of New York, referred to throughout the Evidence of Coverage as "we," "us," or "our." **Medco Medicare Prescription Plan** (PDP) is referred to as "Plan" or "our Plan."

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of **Medco Medicare Prescription Plan** (PDP).

Section 1.2 What does this Chapter tell you?

Look through **Chapter 1** of this Evidence of Coverage to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- What is your plan's service area?
- How do you keep the information in your membership record up to date?

Section 1.3 What if you are new to *Medco Medicare Prescription Plan* (PDP)?

If you are a new member, then it's important for you to learn how the Plan operates — what the rules are and what coverage is available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (contact information is on the cover of this booklet).

Section 1.4 Legal information about the Evidence of Coverage

It's part of our contract with you

This Evidence of Coverage is part of our contract with you about how **Medco Medicare Prescription Plan** (PDP) covers your care. Other parts of this contract include the List of Covered Drugs (Formulary), and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders," or "amendments."

The contract is in effect for months in which you are enrolled in **Medco Medicare Prescription Plan** (PDP) between January 1, 2010, to December 31, 2010.

Medicare must approve our Plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve **Medco Medicare Prescription Plan** (PDP) 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.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

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

- You live in our geographic service area (**Section 2.3** below describes our service area)
- — and — you are entitled to Medicare Part A, or you are enrolled in Medicare Part B (or you have both Part A and Part B)

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by providers such as hospitals, skilled nursing

facilities, or home health agencies.

- Medicare Part B is for most other medical services, such as physicians' services and other outpatient services.

Section 2.3 Here is the plan service area for *Medco Medicare Prescription Plan* (PDP)

Although Medicare is a Federal program, **Medco Medicare Prescription Plan** (PDP) is available only to individuals who live in our Plan service area. To stay a member of our Plan, you must keep living in this service area. The service area is described below.

Our service area includes these states:

Alabama	Maine	Oregon
Alaska	Maryland	Pennsylvania
Arizona	Massachusetts	Rhode Island
Arkansas	Michigan	South Carolina
California	Minnesota	South Dakota
Colorado	Mississippi	Tennessee
Connecticut	Missouri	Texas
Delaware	Montana	Utah
Florida	Nebraska	Vermont
Georgia	Nevada	Virginia
Hawaii	New Hampshire	Washington
Idaho	New Jersey	West Virginia
Illinois	New Mexico	Wisconsin
Indiana	New York	Wyoming
Iowa	North Carolina	
Kansas	North Dakota	* District of Columbia
Kentucky	Ohio	* Puerto Rico
Louisiana	Oklahoma	

* The District of Columbia is a Federal district and Puerto Rico is a territory of the United States.

We offer coverage in all states and several territories. If you move out of the state where you live into a state that is still within our service area, you must call Customer Service in order to update your information. If you move into a state outside of our service area, you cannot remain a member of our plan. Please call Customer Service to find out if we have a plan in your new area.

If you plan to move out of the service area, please contact Customer Service.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered prescription drugs

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

Medco Medicare Prescription Plan® (PDP)

RxBin	610014
RxPcn	MEDDPRIME
RxGrp	RXMEDD1
Issuer	80840
ID No.	123456789012
Name	John Q. Sample

MedicareRx
Prescription Drug Coverage

SAMPLE

Submit prescription claims to:
Medco Health Solutions, Inc.,
P.O. Box 14718, Lexington, KY 40512

Customer Service:
1-800-XXX-XXXX

TTY/TDD line:
1-800-716-3231

www.medco.com

SAMPLE

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.

Section 3.2 The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

Our Pharmacy Directory gives you a complete list of our network pharmacies — that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the Pharmacy Directory to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our Plan to cover (help you pay for) them.

We will send you a complete Pharmacy Directory **at least once every 3 years.** Every year that you don't get a new Pharmacy Directory, we'll send you a booklet that shows changes to the directory.

If you don't have the Pharmacy Directory, you can get a copy from Customer Service (phone numbers are on the front cover). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at **www.medco.com**.

Section 3.3 The plan's List of Covered Drugs (Formulary)

The Plan has a List of Covered Drugs (Formulary). We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by **Medco Medicare Prescription Plan** (PDP). The drugs on this list are selected by the Plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the **Medco Medicare Prescription Plan** (PDP) Drug List.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (**www.medco.com**) or call Customer Service (phone numbers are on the front cover of this booklet).

Section 3.4 Reports with a summary of payments made for your prescription drugs

When you use your prescription drug benefits, we will send you a report to help you understand and keep track of payments for your prescription drugs. This summary report is called the Explanation of Benefits.

The Explanation of Benefits tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. **Chapter 4 (What you**

pay for your Part D prescription drugs) gives more information about the Explanation of Benefits and how it can help you keep track of your drug coverage.

An Explanation of Benefits summary is also available upon request. To get a copy, please contact Customer Service. In addition to receiving your Explanation of Benefits in the mail, you may access a copy by visiting our website.

SECTION 4 Your monthly premium for *Medco Medicare Prescription Plan* (PDP)

Section 4.1 Your monthly plan premium

As a member of our Plan, you pay a monthly plan premium. Your coverage is provided through contract with your current employer or former employer or union. Please contact the employer's benefits administrator for information about your plan premium.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. **Chapter 2, Section 7** tells more about these programs. If you qualify for one of these programs, enrolling in the program might make your monthly plan premium lower.

If you are *already enrolled* and getting help from one of these programs, **some of the payment information in this Evidence of Coverage may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), that tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Service are on the front cover.

In some situations, your plan premium could be more

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible, or because they had a continuous period of 63 days or more when they didn't keep their coverage. For these members, the plan's monthly premium will be higher. It will be the monthly plan premium, plus the amount of their late enrollment penalty.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. **Chapter 4, Section 9** explains the late enrollment penalty.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, 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. You must continue paying your Medicare Part B premium for you to remain as a member of the plan.

- Your copy of "Medicare & You 2010" tells about these premiums in the section called "2010 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of "Medicare & You" each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of "Medicare & You 2010" from the Medicare website (http://www.medicare.gov). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY/TDD users call 1-877-486-2048.

Section 4.2 There are two ways you can pay your plan premium

Pay your plan premium directly to the Plan. You may pay your premium by pension payroll deduction or bank draft. Premiums for the current month are drafted against the bank account, on or about, the 7th of each month. Drafts returned due to insufficient funds will not be resubmitted. During the next month's regular bank processing, the account will be drafted for both the current month's premium plus any past-due amounts. This will only be allowed four times in a 24-month period, beginning from the date of the first insufficient bank draft. After the third NSF (Not Sufficient Funds), a "Notice of Coverage Cancellation" will be issued. The notice will state that coverage will be canceled if a fourth NSF occurs. If you have any questions about your plan premiums or the different ways to pay them, please call the TVA Service Center at 1-888-275-8094.

What to do if you are having trouble paying your plan premium

Failure to pay your premiums will result in your disenrollment after a grace period of at least 30 days.

If you are having trouble paying your premium on time, please contact TVA. If your membership with the Plan ends because of non-payment of premiums, and you don't currently have prescription drug coverage, then you will not be able to receive Part D coverage until the Annual Election Period. At that time, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage.

If your membership ends due to non-payment of premiums, you will also lose your medical coverage. If you are disenrolled due to non-payment of premiums, you will not be able to re-enroll in our plan.

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in October and the change will take effect on January 1.

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for Extra Help or if you lose your eligibility for Extra Help during the year. If a member qualifies for Extra Help with their prescription drug costs, Extra Help will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about Extra Help in **Chapter 2, Section 7.**

What if you believe you have qualified for Extra Help

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our Plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or if you already have the evidence, to provide this evidence to us. Once we receive your supporting documentation, your level of extra help will be updated to reflect the correct information.

The acceptable forms of documentation are as follows:

- A copy of a member's Medicaid card, which includes the member's name and the eligibility date during the discrepant period;
- The date that a verification call was made to the state Medicaid agency, the name and telephone number of the state staff person who verified the Medicaid period, and the Medicaid eligibility dates confirmed on the call;
- A copy of a state document that confirms active Medicaid status during the discrepant period;
- A screen print from the state's Medicaid systems showing Medicaid status during the discrepant period;
- Evidence at point of sale of recent Medicaid billing and payment in the pharmacy's patient profile, backed up by one of the above indicators post point of sale;
- A copy of a letter from the state or SSA showing Medicare Low-Income Subsidy status; or
- An award letter from the Social Security Administration confirming Extra Help eligibility during the discrepant period.

Proofs of institutional status for a full-benefit dual eligible:

- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar

month on behalf of the individual; or

- A screen print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

When we receive the evidence showing your co-payment level, we will update our system so that you can pay the correct co-payment when you get your next prescription at the pharmacy. If you overpay your co-payment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. If the pharmacy hasn't collected a co-payment from you and is carrying your co-payment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your eligibility record, including your address and telephone number. It shows your specific plan coverage.

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.** Because of this, it is very important that you help us keep your information up to date.

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 (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

Read over the information we send you about any other insurance coverage you have

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 (phone numbers are on the cover of this booklet).

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SECTION 1 **Medco Medicare Prescription Plan** (PDP) **contacts** (how to contact us, including how to reach Customer Service at the Plan)

How to contact our plan's Customer Service

For assistance with claims, billing, or Member ID card questions, please call or write to **Medco Medicare Prescription Plan** (PDP) Customer Service. We will be happy to help you.

Customer Service	
CALL	**1-800-592-4520** Calls to this number are free. Customer Service is available 24 hours a day, 7 days a week (except Thanksgiving and Christmas). Customer Service is available in English and other languages.
TTY/TDD	**1-800-716-3231** 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	**1-888-235-8551**
WRITE	Medco Medicare Prescription Plan (PDP) Medco Health Solutions, Inc. P.O. Box 14570 Lexington, KY 40512
WEBSITE	**www.medco.com**

How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs

You may call us if you have questions about our coverage decision and appeals process.

Coverage Decisions and Appeals for Part D Prescription Drugs	
CALL	**1-800-753-2851** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
TTY/TDD	**1-800-716-3231** 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	**1-888-235-8551**
WRITE	Medco Health Solutions, Inc. Attn: Medicare Reviews P.O. Box 630367 Irving, TX 75063-0118

For more information on asking for coverage decisions or an appeal about your Part D prescription drugs, see **Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**

How to contact us when you are making a complaint about your Part D prescription drugs

Complaints about Part D Prescription Drugs	
CALL	**1-800-592-4520** Calls to this number are free. Customer Service is available 24 hours a day, 7 days a week (except Thanksgiving and Christmas). Customer Service is available in English and other languages.
TTY/TDD	**1-800-716-3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Medco Medicare Prescription Plan (PDP) Medco Health Solutions, Inc. Attn: Service Grievance Resolution Team P.O. Box 639405 Irving, TX 75063-9405

For more information on making a complaint about your Part D prescription drugs, see **Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**

Where to send a request that asks us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests that asks us to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the Plan for reimbursement or to pay a bill you have received from a provider, see **Chapter 5 (Asking the Plan to pay its share of the costs for covered drugs).**

Payment Requests	
CALL	**1-800-592-4520** Calls to this number are free. Customer Service is available 24 hours a day, 7 days a week (except Thanksgiving and Christmas). Customer Service is available in English and other languages.

TTY/TDD	**1-800-716-3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Medco Health Solutions, Inc. P.O. Box 14718 Lexington, KY 40512

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

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).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare prescription drug plans, including us.

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free, 24 hours a day, 7 days a week.
TTY/TDD	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 This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the numbers above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please refer to the SHIP listing to find what the SHIP in your state is called.

The State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

State Health Insurance Assistance Program (SHIP) 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, and help you straighten out problems with your Medicare bills. State Health Insurance Assistance Program (SHIP) counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

State Health Insurance Assistance Programs (SHIPs)

Alabama	**State Health Insurance Assistance Program (SHIP)** **Alabama Department of Senior Services** 770 Washington Avenue, RSA Plaza Suite 470 Montgomery, AL 36130-1851	toll-free: 1-800-243-5463 local: 1-334-242-5743 TTY/TDD: 1-334-242-0995
Alaska	**Alaska State Health Insurance Assistance Program (SHIP)** **Alaska Medicare /Medicare Information Office** 3601 C Street, Suite 310 Anchorage, AK 99503-5984	toll-free: 1-800-478-6065 *(in-state calls only)* local: 1-907-269-3680 TTY/TDD: 1-907-269-3691
Arizona	**State Health Insurance Assistance Program** **DES Division of Aging and Adult Services** 1789 West Jefferson Street, Site Code 950A Phoenix, AZ 85007	toll-free: 1-800-432-4040 local: 1-602-542-6595 TTY/TDD: 1-602-542-6366
Arkansas	**Senior Health Insurance Information Program** **Arkansas Insurance Department** 1200 West Third Street Little Rock, AR 72201	toll-free: 1-800-224-6330 local: 1-501-371-2782
California	**Health Insurance Counseling and Advocacy Program (HICAP)** 1300 National Drive, Suite 200 Sacramento, CA 95834-1992	toll-free: 1-800-434-0222 *(in-state calls only)* TTY/TDD: 1-800-735-2929
Colorado	**Colorado Senior Health Insurance Assistance Program** 1560 Broadway, Suite 850 Denver, CO 80202	toll-free: 1-888-696-7213 local: 1-800-544-9181 TTY/TDD: 1-303-894-7880
Connecticut	**CHOICES** **Connecticut Department of Social Services** **Aging Services Division** 25 Sigourney Street, 10th Floor Hartford, CT 06106	toll-free: 1-800-994-9422 *(in-state calls only)* local: 1-860-424-5274
Delaware	**ELDERinfo** **Delaware Insurance Department** 841 Silver Lake Boulevard Dover, DE 19904	toll-free: 1-800-336-9500 *(in-state calls only)* local: 1-302-674-7364

State Health Insurance Assistance Programs (SHIPs)

District of Columbia	**Washington, D.C. Health Insurance Counseling Project (HICP)** 2136 Pennsylvania Avenue, NW Washington, D.C. 20052	local: 1-202-739-0668 TTY/TDD: 1-202-973-1079
Florida	**SHINE Program** **Florida Department of Elder Affairs** 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000	toll-free: 1-800-963-5337 local: 1-850-414-2060 TTY/TDD: 1-800-955-8771
Georgia	**GeorgiaCares** **Division of Aging Services** 2 Peachtree Street, NW, Suite 9385 Atlanta, GA 30303-3142	toll-free: 1-800-669-8387 local: 1-404-657-5334 TTY/TDD: 1-404-657-1929
Hawaii	**Sage PLUS** 250 South Hotel Street, Suite 406 Honolulu, HI 96813-2831	toll-free: 1-888-875-9229 local: 1-808-586-7299 TTY/TDD: 1-866-810-4379
Idaho	**Senior Health Insurance Benefits Advisors (SHIBA) of Idaho** 700 West State Street Boise, ID 83720-0043	toll-free: 1-800-247-4422 *(in-state calls only)* local: 1-208-334-4350
Illinois	**Senior Health Insurance Program (SHIP)** 320 W. Washington Street Springfield, IL 62767-0001	toll-free: 1-800-548-9034 *(in-state calls only)* local: 1-217-785-9021 TTY/TDD: 1-217-524-4872
Indiana	**Indiana State Health Insurance Assistance Program (SHIP)** 714 West 53rd Street Anderson, IN 46013	toll-free: 1-800-452-4800 local: 1-765-608-2318
Iowa	**Senior Health Insurance Information Program (SHIIP)** 330 Maple Street Des Moines, IA 50319-0065	toll-free: 1-800-351-4664 local: 1-515-281-5705 TTY/TDD: 1-800-735-2942
Kansas	**Senior Health Insurance Counseling for Kansas (SHICK)** New England Building 503 S. Kansas Avenue Topeka, KS 66603-3404	toll-free: 1-800-860-5260 local: 1-316-337-7386

State Health Insurance Assistance Programs (SHIPs)

Kentucky	**State Health Insurance Assistance Program (SHIP)** **Kentucky Cabinet for Health and Family Services** 275 E. Main Street Frankfort, KY 40621	toll-free: 1-877-293-7447 local: 1-502-564-6930
Louisiana	**Louisiana Senior Health Insurance Information Program** P.O. Box 94214 Baton Rouge, LA 70804-9214	toll-free: 1-800-259-5301 *(in-state calls only)* local: 1-225-342-5301
Maine	**Maine State Health Insurance Assistance Program** **Department of Health and Human Services** **Office of Elder Services** 11 State House Station Augusta, ME 04333	toll-free: 1-800-262-2232 local: 1-207-287-9200 TTY/TDD: 1-800-606-0215
Maryland	**Maryland Senior Health Insurance Assistance Program** **Maryland Department of Aging** 301 West Preston Street, Suite 1007 Baltimore, MD 21201-2374	toll-free: 1-800-243-3425 *(in-state calls only)* local: 1-410-767-1100 TTY/TDD: 1-410-767-1083
Massachusetts	**Serving Health Information Needs of Elders (SHINE)** 1 Ashburton Place, 5th Floor Boston, MA 02108	toll-free: 1-800-243-4636 local: 1-617-727-7750 TTY/TDD: 1-800-872-0166
Michigan	**Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.)** 6105 W. St. Joseph, Suite 204 Lansing, MI 48917-4850	toll-free: 1-800-803-7174 local: 1-517-886-1242
Minnesota	**Minnesota SHIP/Senior LinkAge Line** P.O. Box 64976 St. Paul, MN 55164-0976	toll-free: 1-800-333-2433 TTY/TDD: 1-800-627-3529
Mississippi	**Mississippi Insurance Counseling and Assistance Program (MICAP)** 750 North State Street Jackson, MS 39202	toll-free: 1-800-948-3090 local: 1-601-359-4929
Missouri	**CLAIM Program of Missouri** 200 North Keene Street Columbia, MO 65201	toll-free: 1-800-390-3330 local: 1-573-817-8320

State Health Insurance Assistance Programs (SHIPs)

Montana	**Montana State Health Insurance Assistance Program (SHIP)** 2030 11th Avenue Helena, MT 59620	toll-free: 1-800-551-3191 *(in-state calls only)*
Nebraska	**Nebraska Senior Health Insurance Information Program (SHIIP)** Terminal Building 941 O Street, Suite 400 Lincoln, NE 68508-3690	toll-free: 1-800-234-7119 local: 1-402-471-2201 TTY/TDD: 1-800-833-0920
Nevada	**State Health Insurance Assistance Program** 1860 East Sahara Avenue Las Vegas, NV 89102	toll-free: 1-800-307-4444 local: 1-702-486-3478
New Hampshire	**NH SHIP - ServiceLink Resource Center** **Health and Human Services** **Bureau of Elderly and Adult Services** 129 Pleasant Street Governor Hugh Gallen State Office Park Concord, NH 03301-3857	toll-free: 1-866-634-9412 *(in-state calls only)* local: 1-603-225-9000
New Jersey	**State Health Insurance Assistance Program** **New Jersey Department of Health and Senior Services** P.O. Box 360 Trenton, NJ 08625-0360	toll-free: 1-800-792-8820 *(in-state calls only)* local: 1-877-222-3737
New Mexico	**Benefits Counseling Program** **New Mexico State Agency on Aging** 2550 Cerrillos Road Santa Fe, NM 87505	toll-free: 1-800-432-2080 *(in-state calls only)* local: 1-505-476-4799
New York	**Health Insurance Information Counseling and Assistance Program (HIICAP)** 2 Empire State Plaza Albany, NY 12223-1251	toll-free: 1-800-701-0501 local: 1-800-342-9871
North Carolina	**North Carolina Seniors' Health Insurance Information Program (SHIIP)** 111 South Boylan Avenue Raleigh, NC 27603	toll-free: 1-800-443-9354 local: 1-919-807-6900 TTY/TDD: 1-919-715-0319

State Health Insurance Assistance Programs (SHIPs)

North Dakota	**State Health Insurance Counseling Program (SHIC)** **North Dakota Insurance Department** State Capitol, Fifth floor 600 East Boulevard Avenue Bismarck, ND 58505-0320	toll-free: 1-888-575-6611 local: 1-701-328-2440 TTY/TDD: 1-800-366-6888
Ohio	**Ohio Senior Health Insurance Information Program (SHIP)** **Ohio Department of Insurance** 50 West Town Street, Suite 300 Columbus, OH 43215	toll-free: 1-800-686-1578 local: 1-614-644-3458 TTY/TDD: 1-614-644-3745
Oklahoma	**Oklahoma Senior Health Insurance Counseling Program (SHIP)** P.O. Box 53408 Oklahoma City, OK 73107	toll-free: 1-800-763-2828 *(in-state calls only)* local: 1-405-521-6628
Oregon	**Oregon Senior Health Insurance Benefits Assistance (SHIBA)** 250 Church Street, SE Suite 200 Salem, OR 97301-3921	toll-free: 1-800-722-4134 local: 1-503-378-2014 TTY/TDD: 1-800-735-2900
Pennsylvania	**APPRISE** 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919	toll-free: 1-800-783-7067 local: 1-717-783-8975 TTY/TDD: 1-717-782-2240
Puerto Rico	**State Health Insurance Assistance Program (SHIP)** P.O. Box 191179 San Juan, PR 00919-1179	toll-free (Bayamon): 1-800-981-1615 toll-free (Ponce): 1-800-981-7735 toll-free (San Juan): 1-877-725-4300 toll-free (Mayagüez) 1-800-981-0056 local: 1-787-721-6121
Rhode Island	**Rhode Island Senior Health Insurance Program (SHIP)** Hazard Building 74 West Road Cranston, RI 02920	local: 1-401-462-4000 TTY/TDD: 1-401-462-0740
South Carolina	**Insurance Counseling Assistance and Referrals for Elders (I-CARE)** **Lieutenant Governor's Office on Aging** 1301 Gervais Street, Suite 200 Columbia, SC 29201	local: 1-803-734-9900

State Health Insurance Assistance Programs (SHIPs)

South Dakota	**Senior Health Information and Insurance Education (SHIINE)** 2300 West 46th Street Sioux Falls, SD 57105	toll-free: 1-800-536-8197
Tennessee	**Tennessee Commission on Aging and Disability** **Andrew Jackson Building** 500 Deaderick Street, 8th Floor Nashville, TN 37243-0860	toll-free: 1-877-801-0044 local: 1-615-741-2056 TTY/TDD: 1-615-532-3893
Texas	**Health Insurance Information Counseling and Advocacy Program (HICAP)** P.O. Box 149030 Austin, TX 78714-9030	toll-free: 1-800-252-9240 local: 1-512-438-3011
Utah	**Health Insurance Information Program (HIIP)** **Aging and Adult Services of Utah** 120 North 200 West, Suite 325 Salt Lake City, UT 84103	toll-free: 1-800-541-7735 *(in-state calls only)* local: 1-801-538-3910
Vermont	**State Health Insurance Assistance Program (SHIP)** 481 Summer Street Suite 101 St. Johnsbury, VT 05819	toll-free: 1-800-642-5119 *(in-state calls only)* local: 1-802-748-5182
Virginia	**Virginia Insurance Counseling and Assistance Program (VICAP)** **Virginia Department for the Aging** 1610 Forest Ave, Suite 100 Richmond, VA 23229	toll-free: 1-800-552-3402 Richmond: 1-804-662-9333
Washington	**Statewide Health Insurance Benefits Advisors** **Office of Insurance Commissioner** P.O. Box 40256 Olympia, WA 98504-0256	toll-free: 1-800-562-6900 TTY/TDD: 1-360-586-0241
West Virginia	**West Virginia State Health Insurance Assistance Program (WV SHIP)** **Bureau of Senior Services of West Virginia** 1900 Kanawha Boulevard East Charleston, WV 25305-0160	toll-free: 1-877-987-4463 local: 1-304-558-3317

State Health Insurance Assistance Programs (SHIPs)		
Wisconsin	**Wisconsin State Health Insurance Assistance Program (SHIP)** **Department of Health Services** 1 West Wilson Street P.O. Box 7850 Madison, WI 53703-2118	toll-free: 1-800-242-1060 local: 1-608-246-7017 TTY/TDD: 1-800-600-7826
Wyoming	**Wyoming State Health Insurance Information Program (WSHIIP)** 106 West Adams P.O. Box BD Riverton, WY 82501	toll-free: 1-800-856-4398 local: 1-307-856-6880

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization in each state. Please refer to the QIO listing to see what the Quality Improvement Organization is called in your state.

The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It is not connected with our Plan.

You should contact the Quality Improvement Organization in your state in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Quality Improvement Organizations (QIOs)

Alabama	**Alabama Quality Assurance Foundation** 2 Perimeter Park South, Suite 200 West Birmingham, AL 35243-2337	local: 1-205-977-4205 toll-free: 1-800-760-3540
Alaska	**Qualis Health** 741 Sesame Street, Suite 100 Anchorage, AK 99503	local: 1-907-770-7525 toll-free: 1-888-578-2547
Arizona	**Health Services Advisory Group, Inc.** 1600 East Northern Avenue, Suite 100 Phoenix, AZ 85020	local: 1-602-264-6382 toll-free: 1-800-359-9909
Arkansas	**Arkansas Foundation for Medical Care** 2201 Brooken Hill Drive Fort Smith, AR 72908	local: 1-479-649-8501 toll-free: 1-888-354-9100
California	**Health Services Advisory Group, Inc.** 700 North Brand Boulevard, Suite 370 Glendale, CA 91203	local: 1-818-409-9229 toll-free: 1-800-841-1602
Colorado	**Colorado Foundation for Medical Care** 23 Inverness Way East, Suite 100 Englewood, CO 80112-5708	local: 1-303-695-3300 toll-free: 1-800-950-8250
Connecticut	**Qualidigm** 1111 Cromwell Avenue, Suite 201 Rocky Hill, CT 06067-3454	local: 1-860-632-2008 toll-free: 1-800-553-7590
Delaware	**Quality Insights of Delaware** Baynard Building, Suite 100 3411 Silverside Road Wilmington, DE 19810-4812	local: 1-302-478-3600 toll-free: 1-866-475-9669
District of Columbia	**Delmarva Foundation of the District of Columbia (DFDC)** 2175 K Street, NW, Suite 250 Washington, DC 20037	local: 1-202-293-9650 toll-free: 1-800-937-3362
Florida	**Florida Medical Quality Assurance (FMQAI)** 5201 W. Kennedy Boulevard Suite 900 Tampa, FL 33609-1822	local: 1-813-354-9111 toll-free: 1-800-844-0795
Georgia	**Georgia Medical Care Foundation** 1455 Lincoln Parkway, Suite 800 Atlanta, GA 30346	local: 1-404-982-0411 toll-free: 1-800-982-0411

Quality Improvement Organizations (QIOs)

Hawaii	**Mountain-Pacific Quality Health Foundation** 1360 South Beretania Street, Suite 501 Honolulu, HI 96814	local: 1-808-545-2550 toll-free: 1-800-524-6550
Idaho	**Qualis Health** 720 Park Boulevard, Suite 120 Boise, ID 83712	local: 1-208-343-4617 toll-free: 1-800-488-1118
Illinois	**Illinois Foundation for Quality Health Care** 711 Jorie Boulevard, Suite 301 Oak Brook, IL 60523-4425	local: 1-630-928-5800 toll-free: 1-800-647-8089 *(in-state calls only)*
Indiana	**Health Care Excel, Inc.** 2629 Waterfront Parkway East Drive, Suite 200 Indianapolis, IN 46214	local: 1-317-347-4500 toll-free: 1-800-288-1499
Iowa	**Iowa Foundation for Medical Care** 1776 West Lakes Parkway West Des Moines, IA 50266	local: 1-515-223-2900 toll-free: 1-800-383-2856
Kansas	**Kansas Foundation for Medical Care** 2947 S.W. Wanamaker Drive Topeka, KS 66614-4193	local: 1-785-273-2552 toll-free: 1-800-432-0770
Kentucky	**Health Care Excel of Kentucky, Inc.** 1941 Bishop Lane, Suite 400 Louisville, KY 40218	local: 1-502-454-5112 toll-free: 1-800-288-1499
Louisiana	**Louisiana Health Care Review, Inc.** 8591 United Plaza Boulevard, Suite 270 Baton Rouge, LA 70809	local: 1-225-926-6353 toll-free: 1-800-433-4958
Maine	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	local: 1-603-749-1641 toll-free: 1-800-772-0151
Maryland	**Delmarva Foundation for Medical Care** 9240 Centreville Road Easton, MD 21601	local: 1-410-822-0697 toll-free: 1-800-999-3362
Massachusetts	**Masspro** 245 Winter Street Waltham, MA 02451-1231	local: 1-781-890-0011 toll-free: 1-800-252-5533 *(in-state calls only)*

Quality Improvement Organizations (QIOs)

Michigan	**Michigan Peer Review Organization** 22670 Haggerty Road Suite 100 Farmington Hills, MI 48335-2611	local: 1-248-465-7300 toll-free: 1-800-365-5899
Minnesota	**Stratis Health** 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525	local: 1-952-854-3306 toll-free: 1-800-444-3423
Mississippi	**Information and Quality Healthcare** 385B Highland Colony Parkway, Suite 504 Ridgeland, MS 39157-6035	local: 1-601-957-1575 toll-free: 1-800-844-0600
Missouri	**Primaris** 200 North Keene Street Columbia, MO 65201	local: 1-573-817-8300 toll-free: 1-800-735-6776
Montana	**Mountain-Pacific Quality Health Foundation** 3404 Cooney Drive Helena, MT 59602	local: 1-406-443-4020 toll-free: 1-800-497-8232
Nebraska	**CIMRO of Nebraska** 1230 O Street, Suite 120 Lincoln, NE 68508	local: 1-402-476-1399 toll-free: 1-800-458-4262
Nevada	**HealthInsight** 6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118	local: 1-702-385-9933 toll-free: 1-800-748-6773
New Hampshire	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	local: 1-603-749-1641 toll-free: 1-800-772-0151
New Jersey	**Healthcare Quality Strategies, Inc. (HQSI)** 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816-5419	local: 1-732-238-5570 toll-free: 1-800-624-4557 *(in-state calls only)*
New Mexico	**New Mexico Medical Review Association** 5801 Osuna Road, NE, Suite 200 Albuquerque, NM 87109	local: 1-505-998-9898 toll-free: 1-800-663-6351
New York	**IPRO** 1979 Marcus Avenue Lake Success, NY 11042-1002	local: 1-516-326-7767 toll-free: 1-800-331-7767

Quality Improvement Organizations (QIOs)

North Carolina	**The Carolinas Center for Medical Excellence (CCME)** 100 Regency Forest Drive, Suite 200 Cary, NC 27518-8598	local: 1-919-380-9860 toll-free: 1-800-682-2650
North Dakota	**North Dakota Health Care Review** 800 31st Avenue, SW Minot, ND 58701	local: 1-701-852-4231 toll-free: 1-888-472-2902
Ohio	**Ohio KePRO, Inc.** Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131	local: 1-216-447-9604 toll-free: 1-800-589-7337
Oklahoma	**Oklahoma Foundation for Medical Quality** 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134-2600	local: 1-405-840-2891 toll-free: 1-800-522-3414
Oregon	**Acumentra Health** 2020 SW Fourth Avenue, Suite 520 Portland, OR 97201	local: 1-503-279-0100 toll-free: 1-800-344-4354
Pennsylvania	**Quality Insights of Pennsylvania** 2601 Market Place Street, Suite 320 Harrisburg, PA 17110	local: 1-717-671-5425 toll-free: 1-877-346-6180
Puerto Rico	**QIPRO, Inc.** 2 Ponce de Leon Avenue Mercantil Plaza Building, Suite 709 San Juan, PR 00918	local: 1-787-641-1240 toll-free: 1-800-981-5062 *(PR calls only)*
Rhode Island	**Quality Partners of Rhode Island** 235 Promenade Street Suite 500, Box 18 Providence, RI 02908	local: 1-401-528-3200 toll-free: 1-800-662-5028
South Carolina	**The Carolinas Center for Medical Excellence** 246 Stoneridge Drive, Suite 200 Columbia, SC 29210	local: 1-803-251-2215 toll-free: 1-800-922-3089
South Dakota	**South Dakota Foundation for Medical Care** 2600 West 49th Sreet, Suite 300 Sioux Falls, SD 57105	local: 1-605-336-3505 toll-free: 1-800-658-2285
Tennessee	**QSource** 3175 Lenox Park Boulevard, Suite 309 Memphis, TN 38115	local: 1-901-682-0381 toll-free: 1-800-489-4633

Quality Improvement Organizations (QIOs)

Texas	**TMF Health Quality Institute** 5918 West Courtyard Drive Bridgepoint I, Suite 300 Austin, TX 78730-5036	local: 1-512-329-6610 toll-free: 1-800-725-8315
Utah	**HealthInsight** 348 East 4500 South, Suite 300 Salt Lake City, UT 84107	local: 1-801-892-0155 toll-free: 1-800-748-6773
Vermont	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	local: 1-603-749-1641 toll-free: 1-800-772-0151
Virginia	**Virginia Health Quality Center** 9830 Mayland Drive, Suite J Richmond, VA 23233	local: 1-804-289-5320 toll-free: 1-800-545-3814
Washington	**Qualis Health** 10700 Meridian Avenue North, Suite 100 P.O. Box 33400 Seattle, WA 98133-9075	local: 1-206-364-9700 toll-free: 1-800-445-6941
West Virginia	**West Virginia Medical Institute** 3001 Chesterfield Avenue Charleston, WV 25304	local: 1-304-346-9864 toll-free: 1-800-642-8686
Wisconsin	**MetaStar** 2909 Landmark Place Madison, WI 53713	local: 1-608-274-1940 toll-free: 1-800-362-2320
Wyoming	**Mountain-Pacific Quality Health Foundation** P.O. Box 2242 409 South 4th Glenrock, WY 82637	local: 1-307-436-8733 toll-free: 1-877-810-6248

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible 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. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the Medicaid agency in your state.

State Medicaid Offices

Alabama	**Alabama Medicaid Agency** 501 Dexter Avenue P.O. Box 5624 Montgomery, AL 36103-5624	local: 1-334-242-5000 toll-free: 1-800-362-1504
Alaska	**Alaska Department of Health and Social Services** 350 Main Street, Room 404 P.O. Box 110601 Juneau, AK 99811	local: 1-907-465-3347 TTY/TDD: 1-907-586-4265
Arizona	**Arizona Health Care Cost Containment System** 801 East Jefferson Phoeniz, AZ 85034	local: 1-602-417-4000 toll-free: 1-800-654-8713 *(outside Maricopa County)* toll-free: 1-800-523-0231 *(within Maricopa County)* TTY/TDD: 1-602-417-4191
Arkansas	**Arkansas Division of Medical Services** **Department of Human Services** Donaghey Plaza South P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437	local: 1-501-682-8233 toll-free: 1-800-482-5431 TTY/TDD: 1-501-682-6789
California	**Medi-Cal** **California Department of Health Services** P.O. Box 997417, MS 4607 Sacramento, CA 95899-7417	local: 1-916-552-9200 (enrollment) TTY/TDD: 1-866-784-2595
Colorado	**Department of Health Care Policy** **and Financing of Colorado** 1570 Grant Street Denver, CO 80203-1818	local: 1-303-866-3513 toll-free: 1-800-221-3943 TTY/TDD: 1-800-659-2656
Connecticut	**Department of Social Services** 25 Sigourney Street Hartford, CT 06106-5033	local: 1-860-424-4908 TTY/TDD: 1-800-842-4524
Delaware	**Delaware Health and Social Services** **Division of Medicaid and Medical Assistance** Lewis Building Herman Holloway Sr. Campus 1901 North DuPont Highway New Castle, DE 19720	local: 1-302-255-9500 toll-free: 1-800-996-9969

State Medicaid Offices

District of Columbia	**Department of Health** 825 North Capitol Street NE 5th Floor Washington, DC 20002	toll-free: 1-888-557-1116
Florida	**Agency for Health Care Administration of Florida** 2727 Mahan Drive Tallahassee, FL 32308	local: 1-850-488-3560 TTY/TDD: 1-800-653-9803
Georgia	**Georgia Department of Community Health** 2 Peachtree Street Northwest Atlanta, GA 30303	toll-free: 1-866-211-0950
Hawaii	**Med-Quest Division** **Department of Human Services** 1390 Miller Street, Room 209 Honolulu, HI 96813	local: 1-808-524-3370 toll-free: 1-800-316-8005 TTY/TDD: 1-808-692-7182
Idaho	**Idaho Department of Health and Welfare** 3232 Elder Street Boise, ID 83705	local: 1-208-334-5747 toll-free: 1-877-200-5441 TTY/TDD: 1-208-332-7205
Illinois	**Illinois Department of Healthcare and Family Services** 201 South Grand Avenue East Springfield, IL 62763-0001	local: 1-217-782-1200 toll-free: 1-866-468-7543 TTY/TDD: 1-877-204-1012
Indiana	**Family and Social Services Administration of Indiana** 402 W. Washington Street P.O. Box 7083 Indianapolis, IN 46207-7083	local: 1-317-233-4454 toll-free: 1-800-889-9949
Iowa	**Department of Human Services of Iowa** P.O. Box 36510 Des Moines, IA 50315	local: 1-515-725-1003 toll-free: 1-800-338-8366
Kansas	**HealthWave** P.O. Box 3599 Topeka, KS 66601	local: 1-785-368-1515 toll-free: 1-800-792-4884 TTY/TDD: 1-800-792-4292
Kentucky	**Department of Medicaid Services** 275 East Main Street Frankfort, KY 40621	local: 1-502-564-4321 toll-free: 1-800-635-2570

State Medicaid Offices

Louisiana	**Louisiana Department of Health and Hospitals** 628 North 4th Street P.O. Box 91030 Baton Rouge, LA 70821-9030	local: 1-225-342-5774 toll-free: 1-888-342-6207 *(in-state calls only)*
Maine	**Office of MaineCare Services** 11 State House Station Augusta, ME 04333-0011	toll-free: 1-800-977-6740 TTY/TDD: 1-800-977-6741
Maryland	**Department of Health and Mental Hygiene** 201 West Preston Street Baltimore, MD 21201	local: 1-410-767-5800 toll-free: 1-800-492-5231 TTY/TDD: 1-800-735-2258
Massachusetts	**Office of Medicaid** 1 Ashburton Place, 11th Floor, Room 1109 Boston, MA 02108	local: 1-617-573-1770 toll-free: 1-800-325-5231
Michigan	**Michigan Department of Community Health** Capitol View Building 201 Townsend Street Lansing, MI 48913	local: 1-517-373-3740 toll-free: 1-800-642-3195 *(in-state calls only)* TTY/TDD: 1-800-649-3777
Minnesota	**Department of Human Services of Minnesota** 444 Lafayette Road North St. Paul, MN 55155	local: 1-651-431-2670 toll-free: 1-800-657-3739 TTY/TDD: 1-800-627-3529
Mississippi	**Mississippi Division of Medicaid** Walter Sillers Building 550 High Street, Suite 1000 Jackson, MS 39201-1399	local: 1-601-359-6050 toll-free: 1-800-421-2408
Missouri	**Department of Social Services of Missouri** 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500	local: 1-573-751-3425 toll-free: 1-800-392-2161 *(in-state calls only)* TTY/TDD: 1-800-735-2966
Montana	**Montana Department of Public Health & Human Services Division of Child and Adult Health Resources** 1400 Broadway, Cogswell Building P.O. Box 8005 Helena, MT 59604-8005	local: 1-406-444-4084 toll-free: 1-800-362-8312 *(in-state calls only)*

State Medicaid Offices

Nebraska	**Nebraska Department of Health and Human Services** P.O. Box 95044 301 Centennial Mall South Lincoln, NE 68509-5044	local: 1-402-471-3121 toll-free: 1-800-430-3244 TTY/TDD: 1-402-471-9570
Nevada	**Nevada Department of Human Resources, Aging Division** 1100 East William Street, Suite 101 Carson City, NV 89710	local: 1-775-684-3600 Las Vegas area: 1-702-668-4200 toll-free: 1-800-992-0900 *(in-state calls only)*
New Hampshire	**New Hampshire Department of Health and Human Services** 129 Pleasant Street Concord, NH 03301-3857	local: 1-603-271-5254 toll-free: 1-800-852-3345 *(in-state calls only)* TTY/TDD: 1-800-735-2964
New Jersey	**Division of Medicaid Assistance and Health Services** Quakerbridge Plaza Building 7 P.O. Box 712 Trenton, NJ 08625-0712	local: 1-609-588-2600 toll-free: 1-800-356-1561 *(in-state calls only)* TTY/TDD: 1-800-852-7899
New Mexico	**Department of Human Services of New Mexico Medical Assistance Division** P.O. Box 2348 Sante Fe, NM 87504-2348	local: 1-505-827-3100 toll-free: 1-888-997-2583 TTY/TDD: 1-505-827-3184
New York	**New York State Department of Health Office of Medicaid Management** Corning Tower, Room 1466 Empire State Plaza Albany, NY 12237-009	local: 1-518-486-9057 toll-free: 1-800-541-2831
North Carolina	**North Carolina Department of Health and Human Services Division of Medical Assistance** 2501 Mail Service Center 1985 Umstead Drive Raleigh, NC 27699-2517	Raleigh area: 1-919-855-4400 toll-free: 1-800-662-7030 *(in-state calls only)* TTY/TDD: 1-877-452-2514
North Dakota	**Department of Human Services of North Dakota - Medical Services** 600 E. Boulevard Avenue, Department 325 Bismarck, ND 58505-0250	local: 1-701-328-2321 toll-free: 1-800-755-2604 TTY/TDD: 1-701-328-3480

State Medicaid Offices

Ohio	**Department of Job and Family Services of Ohio - Ohio Health Plans** 30 East Broad Street, 31st Floor Columbus, OH 43215-3414	local: 1-614-644-0140 toll-free: 1-800-324-8680 TTY/TDD: 1-800-292-3572
Oklahoma	**Health Care Authority of Oklahoma** 4545 N. Lincoln Boulevard Suite 124 Oklahoma City, OK 73105	local: 1-405-522-7171 toll-free: 1-800-522-0310 TTY/TDD: 1-405-522-7179
Oregon	**Office of Medical Assistance Programs** 500 NE Summer Street, 3rd Floor Salem, OR 97301-1079	local: 1-503-945-5772 toll-free: 1-800-527-5772 *(in-state calls only)* TTY/TDD: 1-503-945-5895
Pennsylvania	**Department of Public Welfare of Pennsylvania Office of Medical Assistance Programs** Health and Welfare Building, Room 515 P.O. Box 2675 Harrisburg, PA 17105-2675	local: 1-717-787-1870 toll-free: 1-800-692-7462 TTY/TDD: 1-800-451-5886
Puerto Rico	**Medicaid Office of Puerto Rico and Virgin Islands** Governor's Office of Elderly Affairs P.O. Box 191179 San Juan, Puerto Rico 00919-1179	local: 1-787-725-4300 toll-free: 1-877-725-4300
Rhode Island	**Department of Human Services of Rhode Island** Louis Pasteur Building 600 New London Avenue Cranston, RI 02920	local: 1-401-462-5300 toll-free: 1-800-984-8989 TTY/TDD: 1-401-462-3363
South Carolina	**South Carolina Department of Health and Human Services** P.O. Box 8206 1801 Main Street Columbia, SC 29202-8206	local: 1-803-898-2500 toll-free: 1-888-549-0820
South Dakota	**Department of Social Services of South Dakota** 700 Governors Drive Richard F. Kneip Building Pierre, SD 57501-2291	local: 1-605-773-3495 toll-free: 1-800-452-7691
Tennessee	**Bureau of TennCare** 301 Great Circle Road Nashville, TN 37243	toll-free: 1-866-311-4287 TTY/TDD: 1-800-772-7647

State Medicaid Offices

Texas	**Health and Human Services Commission of Texas** Brown-Healey Building 4900 North Lamar Boulevard, 4th Floor Austin, TX 78751-2316	local: 1-512-424-6500 toll-free: 1-800-252-8263 TTY/TDD: 1-800-735-2989
Utah	**Utah Department of Health** **Division of Healthcare Financing** P.O. Box 143106 Salt Lake City, UT 84114-3106	local: 1-801-538-6155 toll-free: 1-800-662-9651
Vermont	**Agency of Human Services of Vermont** 312 Hurricane Lane, Suite 201 Williston, VT 05495	local: 1-802-879-5900 toll-free: 1-800-250-8427 *(in-state calls only)* TTY/TDD: 1-888-834-7898
Virginia	**Department of Medical Assistance Services** 600 East Broad Street, Suite 1300 Richmond, VA 23219	local: 1-804-786-7933 toll-free: 1-800-643-2273 TTY/TDD: 1-800-343-0634
Washington	**Department of Social and** **Health Services of Washington** P.O. Box 45505 Olympia, WA 98504-5505	toll-free: 1-800-562-3022 *(in-state calls only)* TTY/TDD: 1-800-848-5429
West Virginia	**West Virginia Department of Health** **& Human Resources** Bureau for Medical Services Office of Medicaid Managed Care Room 251 350 Capitol Street Charleston, WV 25301-3708	local: 1-304-558-1700
Wisconsin	**Wisconsin Department** **of Health and Family Services** 1 West Wilson Street, Room 350 P.O. Box 309 Madison, WI 53701-0309	local: 1-608-221-5720 toll-free: 1-800-362-3002 TTY/TDD: 1-888-701-1251
Wyoming	**Office of Medicaid** Qwest Building 6101 Yellowstone Road, Suite 210 Cheyenne, WY 82002	local: 1-307-777-7531 TTY/TDD: 1-307-777-5578

SECTION 7 Information about programs to help people pay for their prescription drugs

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. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription co-payments or coinsurance. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

If you think you may qualify for Extra Help, call Social Security (see **Section 5** of this chapter for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid office (see **Section 6** of this chapter for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Pharmaceutical Assistance Programs

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.

The State Pharmaceutical Assistance Program is a state organization that provides limited-income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

State Pharmacy Assistance Programs (SPAPs)

Colorado	**Colorado Ryan White Title II ADAP** Colorado Department of Public Health and Environment DCEED-STD-A3 4300 Cherry Creek Drive South Denver, CO 80246-1530	local: 1-303-692-2783 1-303 692-2748
Connecticut	**Pharmaceutical Assistance Contract to the Elderly and the Disabled Program (ConnPACE)** **Connecticut Department of Social Services** P.O. Box 5011 Hartford, CT 06102	toll-free: 1-800-423-5026 *(in-state calls only)* out-of-state: 1-860-269-2029
Delaware	**Chronic Renal Disease Program (CRDP)** Milford State Service Center 11-13 Church Avenue Milford, DE 19963	local: 1-302-424-7180 Delaware Help Line: 1-800-464-4357
Delaware	**Delaware Prescription Assistance Program** **The Division of Social Services** P.O. Box 950 New Castle, DE 19720-9914	toll-free: 1-800-996-9969
Idaho	**IDAGAP** Dept. of Health and Welfare 450 West State Street, 4th Floor P.O. Box 83720 Boise, ID 83720-0036	local: 1-208-334-6527
Illinois	**Illinois Cares RX** **Illinois Department on Aging** P.O. Box 19022 Springfield, IL 62794-9022	toll-free: 1-800-252-8966 TTY/TDD: 1-888-206-1327
Indiana	**HoosierRx** P.O. Box 6224 Indianapolis, IN 46206-6224	toll-free: 1-866-267-4679 local: 1-317-234-1381
Maine	**Low-Cost Drugs for the Elderly and Disabled Program (DEL)** **Office of Elder Services** Maine Department of Health and Human Services 11 State House Station 32 Blossom Lane Augusta, ME 04333	toll-free: 1-866-796-2463 TTY/TDD: 1-800-423-4331

State Pharmacy Assistance Programs (SPAPs)

Maryland	**Kidney Disease Program of Maryland** 201 West Preston Street, Room SS-3 Baltimore, MD 21201	local: 1-410-767-5000
Maryland	**Maryland Senior Prescription Drug Assistance Program (SDPAP)** c/o Pool Administrators 100 Great Meadow Road Suite 705 Wethersfield, CT 06109	toll-free: 1-800-551-5995 TTY/TDD: 1-800-877-5156
Massachusetts	**Prescription Advantage Plan** P.O. Box 15153 Worcester, MA 01615-0153	toll-free: 1-800-243-4636 TTY/TDD: 1-677-610-0241
Missouri	**Missouri Rx Plan** P.O. Box 6500 205 Jefferson Street, 14th Floor Jefferson City, MO 65102-6500	toll-free: 1-800-375-1406
Montana	**Big Sky Rx Program** P.O. Box 202915 Helena, MT 59620-2915	toll-free: 1-866-369-1233 *(in-state calls only)* out-of-state & Helena: 1-406-444-1233
Montana	**Montana Mental Health Program** Mental Health Services Program Addictive and Mental Disorders Division 555 Fuller Avenue P.O. Box 202905 Helena MT 59620-2905	local: 1-406-444-3964
Nevada	**Nevada Senior Rx/Nevada Disability Rx** **Department of Health and Human Resources** 4126 Technology Way, Suite 101 Carson City, NV 89706-2009	toll-free: 1-866-303-6323 local (Reno, Carson City, Gardnerville): 1-775-687-7555
New Jersey	**Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)** **Division of Senior Benefits and Utilization Management** **New Jersey Department of Health & Senior Services** P.O. Box 715 Trenton, NJ 08625-0715	toll-free: 1-800-792-9745

State Pharmacy Assistance Programs (SPAPs)

New Jersey	**Senior Gold** **Division of Senior Benefits and Utilization Management** **New Jersey Department of Health & Senior Services** P.O. Box 724 Trenton, NJ 08625-0724	toll-free: 1-800-792-9745
New York	**Elderly Pharmaceutical Insurance Coverage (EPIC)** P.O. Box 15018 Albany, NY 12212-5018	toll-free: 1-800-332-3742 TTY/TDD: 1-800-290-9138
North Carolina	**NCRx** P.O. Box 10068 Raleigh, NC 27690-2724	toll-free: 1-888-488-6279
Pennsylvania	**The Chronic Renal Disease Program** Pennsylvania Department of Health Division of Child and Adult Health Services 625 Forster Street 7th Floor, East Wing Harrisburg, PA 17120-0701	toll-free: 1-800-225-7223
Pennsylvania	**PACE/PACENET Program** Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101	toll-free: 1-800-225-7223 local: 1-717-787-7313
Pennsylvania	**Special Pharmaceutical Benefits Program (SPBP)** P.O. Box 8021 Harrisburg, PA 17105-8021	toll-free: 1-800-922-9384 *(in-state calls only)* local: 1-717-772-6228
Rhode Island	**Rhode Island Prescription Assistance for the Elderly (RIPAE)** Attention: RIPAE, Department of Elderly Affairs John O. Pastore Center Benjamin Rush Building #55 35 Howard Avenue Cranston, RI 02920	local: 1-401-462-3000
South Carolina	**Gap Assistance Pharmacy Program for Seniors (GAPS)** **Department of Health and Human Services** P.O. Box 8206 Columbia, SC 29202	toll-free: 1-888-549-0820

State Pharmacy Assistance Programs (SPAPs)

Texas	**Kidney Health Care Program** Department of State Health Services, MC 1938 P.O. Box 149347 Austin, TX 78714-9347	toll-free: 1-800-222-3986 local: 1-512-458-7150
Texas	**Texas HIV State Pharmaceutical Assistance Program (SPAP)** Texas Department of State Health Services ATTN: MSJA MC 1873 P.O. Box 149347 Austin, TX 78714-9347	toll-free: 1-800-255-1090
Vermont	**VPharm** Health Access Eligibility Unit 3 North 103 South Main Street Waterbury, VT 05671-1301	toll-free: 1-800-250-8427 TTY/TDD: 1-888-834-7898
Virginia	**Department of Health HIV SPAP** Patient Services Incorporated P.O. Box 1602 Midlothian, VA 23113	toll-free: 1-800-366-7741
Virginia	**DMHMRSAS Community SPAP** Department of Behavioral Health and Developmental Services P.O. Box 1797 Richmond, VA 23218-1797	toll-free: 1-800-451-5544 local: 1-804-786-3921 TTY/TDD: 1-804-371-8977
Washington	**Washington State Health Insurance Pharmacy Assistance Program** P.O. Box 1090 Great Bend, KS 67530	toll-free: 1-800-877-5187
Wisconsin	**Health Insurance Risk Sharing Plan (HIRSP)** Customer Service 1751 West Broadway P.O. Box 8961 Madison, WI 53708-8961	toll-free: 1-800-828-4777 local: 1-608-221-4551
Wisconsin	**Wisconsin Chronic Disease Program** (Chronic Renal Disease, Cystic Fibrosis, and Hemophilia Home Care Programs) P.O. Box 6410 Madison, WI 53716-0410	toll-free: 1-800-947-9627

State Pharmacy Assistance Programs (SPAPs)		
Wisconsin	**Wisconsin SeniorCare** P.O. Box 6710 Madison, WI 53716-0710	toll-free: 1-800-657-2038

SECTION 8 How to contact the 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.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 a.m. to 3:30 p.m., Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY/TDD	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

SECTION 9 Do you have "group insurance" or other health insurance from an employer (other than through TVA)?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health or drug benefits, premiums, or enrollment period.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our Plan.

CHAPTER 3: Using the plan's coverage for your Part D prescription drugs

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Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. For more information, see **Chapter 2, Section 7.**

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), that tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Service are on the front cover.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs **(Chapter 4, What you pay for your Part D prescription 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.

This chapter explains rules for using your coverage for Part D drugs under our Plan. The next chapter tells what you pay for Part D drugs **(Chapter 4, What you pay for your Part D prescription drugs).**

Section 1.2 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 use a network pharmacy to fill your prescription. (See **Section 2, Fill your prescriptions at a network pharmacy or through the plan's mail-order service.**)
- Your drug must be on the plan's List of Covered Drugs (Formulary) (we call it the Drug List for short). (See **Section 3, Your drugs need to be on the plan's Drug List.**)
- Your drug must be considered medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies.

A network pharmacy is a pharmacy that has a contract with the Plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by the Plan.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

You can look in your Pharmacy Directory, visit our website (**www.medco.com**), or call Customer Service (phone numbers are on the cover). Choose whatever is easiest for you.

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 to either have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the 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, you can get help from Customer Service (phone numbers are on the cover) or use the Pharmacy Directory.

What if you need a non-retail network pharmacy?

Sometimes prescriptions must be filled at a non-retail network pharmacy. Non-retail network pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. 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 Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations, require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate a non-retail network pharmacy, look in your Pharmacy Directory or call Customer Service.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. These drugs are marked as **"mail-order" drugs** on our plan's Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

You can save money by using mail-order service. You can order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, either visit our website or call Customer Service at the numbers listed on the cover. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 10 days. However, sometimes your mail order may be delayed. Make sure you have at least a 14-day supply of that medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a 30-day supply and fill it at a retail network pharmacy while you wait for your mail-order supply to arrive. If your mail-order shipment is delayed, please call Customer Service at the numbers listed on the cover. We'll make sure you have your medication when you need it.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. The Plan offers two ways to get a long-term supply of mail-order drugs on our plan's Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Some of these retail pharmacies agree to accept a lower cost-sharing amount for a long-term supply of mail-order drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for an extended supply of mail-order drugs. In this case you will be responsible for the difference in price. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Customer Service for more information.
2. For most kinds of drugs, you can use the plan's network **mail-order service.** These drugs are marked as mail-order drugs on our plan's Drug List. You can save money by using the mail-order service. You can order up to a 90-day supply. See **Section 2.3** for more information about using our mail-order service.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription might be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

In a medical emergency. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

When traveling away from our plan's service area. If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our mail-order pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed in **Chapter 2, Section 1** to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

To obtain a covered drug in a timely manner. In some cases, you may be unable to obtain a covered drug

in a timely manner within our service area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy.

If a network pharmacy does not stock a covered drug. Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible retail network pharmacy or through our mail-order pharmacy service. We will cover prescriptions at an out-of-network pharmacy under these circumstances.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the Plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (**Chapter 5, Section 2.1** explains how to ask the Plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

The Plan has a List of Covered Drugs (Formulary). In this Evidence of Coverage, **we call it the Drug List for short.**

The drugs on this list are selected by the Plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, **Section 1.1** explains about Part D drugs).

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 the drug is medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

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. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs.

What is *not* on the Drug List?

The Plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see **Section 7.1** in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are four cost-sharing tiers for drugs on the Drug List

Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

The four cost-sharing tiers on our Drug List are as follows:

Tier 1 - This is our generics cost-sharing tier.

Tier 2 - This is our preferred brand-name cost-sharing tier.

Tier 3 - This is our non-preferred brand-name cost-sharing tier.

Tier 4 - This is our specialty cost-sharing tier.

Tier 1 is our lowest price tier and Tier 4 is the highest price tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in **Chapter 4 (What you pay for your Part D prescription drugs).**

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (**www.medco.com**). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are on the front cover.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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.

In general, our rules encourage you get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor or other prescriber to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

Section 4.2 What kinds of restrictions?

Our Plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Using generic drugs whenever you can

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 must provide you the generic version.** However, if your doctor has told us the medical reason that the generic drug will not work for you, then 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.)

Getting plan approval in advance

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 plan approval is required so we can be sure that your drug is covered by Medicare rules. 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.

Trying a different drug first

This requirement encourages you to try safer or more 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. For example, the Plan might 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.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are on the front cover) or check our website (**www.medco.com**).

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your doctor 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?** As explained in **Section 4,** some of the drugs covered by the Plan have extra rules to restrict their use. 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 (number of pills, etc.) 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 four 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. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to **Section 5.2** to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to **Section 5.3** to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply) until you and your doctor decide it is okay to change to another drug, or while you file an exception.
- You can change to another drug.
- You can request an exception and ask the Plan to cover the drug or remove restrictions from the drug covered.

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 doctor 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:

- The drug you have been taking is **no longer on the plan's Drug List.**
- – or – the drug you have been taking is **now restricted in some way** (**Section 4** in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the Plan last year:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year.** This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **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 a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those who are new members and are residents 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 a maximum of 31 days, 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.

- **For those who have been a member of the Plan for more than 90 days and are a resident of 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.

To ask for a temporary supply, call Customer Service (phone numbers are on the front cover).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the Plan that might work just as well for you. Or you and your doctor can ask the Plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug covered by the Plan 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 doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor or other prescriber 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 doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber 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 doctor or other prescriber want to ask for an exception, **Chapter 7** 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.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

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 doctor or other prescriber. 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 doctor or other prescriber to find a covered drug that might work for you.

You can file an exception

You and your doctor or other prescriber 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 doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule.

If you and your doctor or other prescriber want to ask for an exception, **Chapter 7** 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.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the Plan might make many kinds of changes to the Drug List. For example, the Plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see **Section 4** in this chapter).
- **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.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the Plan will send you a notice to tell you. 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 doctor will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

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, but not because of 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 doctor to switch to the generic or to a different drug that we cover.
    - Or you and your doctor or other prescriber 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 7 (What to do if you have a problem or complaint).**
- 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 doctor or other prescriber will also know about this change and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by the Plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." Excluded means that the Plan doesn't cover these types of drugs because the law doesn't allow any Medicare drug plan to cover them.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section (unless our Plan covers certain excluded drugs). The only exception: 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. (For information about appealing a decision we have made to not cover a drug, go to **Chapter 7** in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- "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.
    - Sometimes off-label use is allowed. Medicare sometimes allows us to cover off-label uses of a prescription drug. Coverage 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 by Medicare drug plans unless we offer enhanced drug coverage, for which you may be charged additional premium:

- Non-prescription drugs (also called over-the-counter drugs)
- 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
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- 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

If you receive extra help paying for your drugs, 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.

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership 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.

Section 8.2 What if you don't have your membership card with you?

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. See **Chapter 5, Section 2.1** for information about how to ask the Plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the Plan?

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. See the previous parts of this chapter that tell about the rules for getting drug coverage.

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 the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

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. (**Chapter 8, Ending your membership in the Plan,** tells you can leave our Plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care 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.

Check your Pharmacy Directory 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, please contact Customer Service.

What if you're a resident in a long-term care facility and become a new member of the Plan?

If you need a drug that is not on our Drug List or is restricted in some way, the Plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 31 days, 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.

If you have been a member of the Plan for more than 90 days and need a drug that is not on our Drug List, or if the Plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the Plan that might work just as well for you. Or you and your doctor 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 you and your doctor want to ask for an exception, **Chapter 7** tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in **Medco Medicare Prescription Plan** (PDP) doesn't 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.

Some drugs may be covered under Medicare Part B in some situations and through **Medco Medicare Prescription Plan** (PDP) in other situations. But drugs are never covered by both Part B and our Plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or **Medco Medicare Prescription Plan** (PDP) for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice by November 15 that tells if your prescription drug coverage is creditable, and the choices you have for drug coverage. (If the coverage from the Medigap policy is **creditable,** it means that it has drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medicare insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan (other than through TVA)?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator.** He or she can help you

determine how your current prescription drug coverage will work with our Plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about creditable coverage: Each year your employer or retiree group should send you a notice by November 15 that tells if your prescription drug coverage for the next calendar year is creditable and 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.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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. We also review our records on a regular basis. During these reviews, we 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.

Section 10.2 Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions, or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

CHAPTER 4: What you pay for your Part D prescription drugs

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Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. For more information, see **Chapter 2, Section 7.**

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), that tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Service are on the front cover.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in **Chapter 3,** some drugs are covered under Original Medicare or are excluded by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's List of Covered Drugs (Formulary).** To keep things simple, we call this the Drug List.
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the four cost-sharing tiers the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Customer Service (phone numbers are on the cover of this booklet). You can also find the Drug List on our website at **www.medco.com**. The Drug List on the website is always the most current.
- **Chapter 3 of this booklet. Chapter 3** gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. **Chapter 3** also tells which types of prescription drugs are not covered by our Plan.

- **The plan's Pharmacy Directory.** In most situations, you must use a network pharmacy to get your covered drugs (see **Chapter 3** for the details). The Pharmacy Directory has a list of pharmacies in the plan's network, and it tells how you can use the plan's mail-order service to get certain types of drugs. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three months' supply).

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the three drug payment stages?

As shown in the table on the next page, there are three drug payment stages for your prescription drug coverage. 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 regardless of the drug payment stage.

STAGE 1	STAGE 2	STAGE 3
Yearly Deductible stage	Initial Coverage stage	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 paid $50 for your drugs. ($50 is the amount of your deductible.) (Details are in **Section 4** of this chapter.)	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 your total out-of-pocket costs reach $4,550. (Details are in **Section 5** of this chapter.)	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. (Details are in **Section 7** of this chapter.)

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

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the Explanation of Benefits

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:

- We keep track of how much you have paid. This is called your **out-of-pocket** cost.
- We keep track of your **total drug costs.** This is the amount you pay out of pocket or others pay on your behalf, plus the amount paid by the Plan.

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

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug 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.

Section 3.2 Help us keep our information about your drug payments 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.** 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. (If you are billed for a covered drug, you can ask our Plan to pay our share of the cost. For instructions on how to do this, go to **Chapter 5, Section 2** of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our Plan's benefit **(Applicable only during your Deductible Stage)**.
- When you made a co-payment for drugs that are provided under a drug manufacturer patient assistance program **(During all stages of the benefit)**.
- Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances **(During all stages of the benefit)**.

- **Check the written report we send you.** When you receive an Explanation of Benefits in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are on the cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible stage, you pay the full cost of your drugs

Section 4.1 You stay in the Deductible stage until you have paid $50 for your drugs

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, which is $50.

- 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 paid $50 for your drugs, you leave the Deductible stage and move on to the next drug payment stage, which is the Initial Coverage stage.

SECTION 5 During the Initial Coverage stage, the Plan pays its share of your drug costs, and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

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.

The Plan has four cost-sharing tiers

Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

The lowest cost-sharing tier in our Plan is Tier 1 and the highest is Tier 4.

Below is a description of what types of drugs are in each cost-sharing tier:

Tier 1: generic drugs

Tier 2: preferred brand-name drugs

Tier 3: non-preferred brand-name drugs

Tier 4: specialty drugs

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see **Chapter 3** in this booklet and the plan's Pharmacy Directory.

Section 5.2 A table that shows your costs for a 30-day supply of a drug

During the Initial Coverage stage, your share of the cost of a covered drug will be a co-payment.

- **Co-payment** means that you pay a fixed amount each time you fill a prescription.

As shown in the table below, the amount of the co-payment depends on which cost-sharing tier your drug is in.

Your share of the cost when you get a 30-day supply (or less) of a covered Part D prescription drug from:

	Network pharmacy	**The plan's mail-order service**	**Network long-term care pharmacy**	**Out-of-network pharmacy** (coverage is limited to certain situations; see Chapter 3 for details)
Cost-Sharing Tier 1 (Generic drugs)	$10.00 co-payment	$20.00 co-payment	$10.00 co-payment	$10.00 co-payment
Cost-Sharing Tier 2 (Preferred brand-name drugs)	$30.00 co-payment	$60.00 co-payment	$30.00 co-payment	$30.00 co-payment
Cost-Sharing Tier 3 (Non-preferred brand-name drugs)	$50.00 co-payment	$100.00 co-payment	$50.00 co-payment	$50.00 co-payment
Cost-Sharing Tier 4 (Specialty drugs)	$50.00 co-payment	$100.00 co-payment	$50.00 co-payment	$50.00 co-payment

Section 5.3 A table that shows your costs for a long-term (up to 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. This can be up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see **Chapter 3.**)

The table below shows what you pay when you get a long-term (up to 90-day) supply of a drug.

Your share of the cost when you get a long-term (up to 90-day) supply of a covered Part D prescription drug from:

	Network pharmacy	The plan's mail-order service
Cost-Sharing Tier 1 (Generic drugs)	$30.00 co-payment	$20.00 co-payment
Cost-Sharing Tier 2 (Preferred brand-name drugs)	$90.00 co-payment	$60.00 co-payment
Cost-Sharing Tier 3 (Non-preferred brand-name drugs)	$150.00 co-payment	$100.00 co-payment
Cost-Sharing Tier 4 (Specialty drugs)	$150.00 co-payment	$100.00 co-payment

Section 5.4 You stay in the Initial Coverage stage until your total out-of-pocket expenses reach $4,550

You stay in the Initial Coverage stage until your total out-of-pocket expenses reach the **$4,550 limit for the Initial Coverage stage.**

Your out-of-pocket cost is based on adding together what you have paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See **Section 6.1** for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The $50 you paid when you were in the Deductible stage.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage stage.

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 $4,550 limit in a year.

We will let you know if you reach this $4,550 amount. If you do reach this amount, you will leave the Initial Coverage stage and move on to the Catastrophic Coverage stage.

SECTION 6 Your out-of-pocket costs

Section 6.1 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments are included in your out-of-pocket costs

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in **Chapter 3** of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible stage
  - The Initial Coverage stage
- Any payments you made during this calendar year under another Medicare prescription drug plan before you joined our Plan.

It matters who pays:

- If you make these payments **yourself,** they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by "Extra Help" from Medicare are also included.

Moving on to the Catastrophic Coverage stage:

When you (or those paying on your behalf) have spent a total of $4,550 in out-of-pocket costs within the calendar year, you will move to the Catastrophic Coverage stage.

These payments **are not included** in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- 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
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments for your drugs that are made by group health plans, including employer health plans
- Payments for your drugs that are made by insurance plans and government-funded health programs, such as TRICARE, the Veterans Administration, the Indian Health Service, or AIDS Drug Assistance Programs
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, workers' compensation)

Reminder: 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 (phone numbers are on the cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The Explanation of Benefits report we send to you includes the current amount of your out-of-pocket costs (**Section 3** above tells about this report). When you reach a total of $4,550 in out-of-pocket costs for the year, this report will tell you that you have moved on to the Catastrophic Coverage stage.
- **Make sure we have the information we need. Section 3** above tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage stage, the Plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage stage when your out-of-pocket costs have reached the $4,550 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.

- **Your share** of the cost for a covered drug will be either coinsurance or a co-payment, whichever is the *larger* amount:
  - *–either –* coinsurance of 5% of the cost of the drug
  - *–or –* a $2.50 co-payment for a generic drug or a drug that is treated like a generic. Or a $6.30 co-payment for all other drugs.
- **Our Plan pays the rest** of the cost.

SECTION 8 What you pay for vaccinations depends on how and where you get them

Section 8.1 Our Plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our Plan provides coverage of a number of vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself.** The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot.** (This is sometimes called the "administration" of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for)

- Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's List of Covered Drugs.

2. **Where you get the vaccine medication**
3. **Who gives you the vaccination shot**

What you pay at the time you get the vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our Plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot. Remember, you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible stage of your benefit.

Situation 1: You buy the vaccine at the 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 the pharmacy the amount of your co-payment or coinsurance 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 by using the procedures that are described in **Chapter 5** of this booklet (Asking the Plan to pay its share of a bill you have received for medical services or drugs).
- You will be reimbursed the amount you paid, less your normal coinsurance or co-payment for the vaccine (including administration).

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.

- You will have to pay the pharmacy the amount of your coinsurance or co-payment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our Plan to pay our share of the cost by using the procedures described in **Chapter 5** of this booklet.
- You will be reimbursed the amount charged by the doctor, less the amount we will pay for administering the vaccine.

Section 8.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are on the cover of this booklet).

- We can tell you about how your vaccination is covered by our Plan and explain your share of the cost.
- We can tell you 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.

SECTION 9 Do you have to pay the Part D late enrollment penalty?

Section 9.1 What is the Part D late enrollment penalty?

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 keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible, or how many months after 63 days you went without drug coverage.

The penalty is added to your monthly premium. (Members who choose to pay their premium every 3 months will have the penalty added to their 3-month premium.) When you first enroll in **Medco Medicare Prescription Plan** (PDP), we let you know the amount of the penalty.

Section 9.2 How much is the Part D 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. For our example, let's say it is 14 months without coverage, which will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2010, this average premium amount is $31.94.
- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents. In the example here, it would be 14% times $31.94, which equals $4.47, which rounds to $4.50. This amount would be added **to your 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 Medicare.

If you are eligible for Medicare and are under 65, any late enrollment penalty you are paying will be eliminated when you attain age 65. After age 65, your late enrollment penalty is based only on the months you do not have coverage after your Age 65 Initial Enrollment Period.

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this **creditable drug coverage.** Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is at least as good as Medicare's.
- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days in a row.
- If you didn't receive enough information to know whether or not your previous drug coverage was creditable.

- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005)–*and*–you signed up for a Medicare prescription drug plan by December 31, 2006–*and*–you have stayed in a Medicare prescription drug plan.
- You are receiving Extra Help from Medicare.

Section 9.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Customer Service at the numbers on the front of this booklet to find out more about how to do this.

CHAPTER 5: Asking the Plan to pay its share of the costs for covered drugs

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SECTION 1 Situations in which you should ask our Plan to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

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). Asking for reimbursement in the first three examples below are types of coverage decisions (for more information about coverage decisions, go to **Chapter 7** of this booklet).

Here are examples of situations in which you may need to ask our Plan to pay you back:

1. 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.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. 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.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

3. 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 List of Covered Drugs (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.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. In a medical emergency

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

5. When traveling away from our plan's service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our mail-order pharmacy service. If you are traveling within the U.S. and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the cover of this booklet to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

6. To obtain a covered drug in a timely manner

In some cases, you may be unable to obtain a covered drug in a timely manner within our service area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy.

7. If a network pharmacy does not stock a covered drug

Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible retail network pharmacy or through our mail-order pharmacy. We will cover prescriptions at an out-of-network pharmacy under these circumstances.

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. **Chapter 7** of this booklet **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, 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.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it's helpful for our Plan to process the information faster.
- Either download a copy of the form from our website (**www.medco.com**) or call Customer Service and ask for the form. The phone numbers for Customer Service are on the cover of this booklet.

Mail your request for payment, together with any receipts, to us at this address:

Medco Health Solutions, Inc.
P.O. Box 14718
Lexington, KY 40512

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.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

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 decide whether to pay it and how much we owe.

- 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 all but your share to you. (**Chapter 3** explains the rules you need to follow for getting your Part D prescription drugs.)
- 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.

Section 3.2 If we tell you that we will not pay for the drug, you can make an appeal

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. The examples of situations in which you may need to ask our Plan to pay you back:

- When you use an out-of-network pharmacy to get a prescription filled
- When you pay the full cost for a prescription because you don't have your plan membership card with you

- When you pay the full cost for a prescription in other situations

For the details on how to make this appeal, go to **Chapter 7** of this booklet **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).** The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading **Section 4** of **Chapter 7. Section 4** is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then, after you have read **Section 4,** you can go to **Section 5** in **Chapter 7** for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send them to the Plan

Section 4.1 In some cases, you should send your receipts to the Plan to help us track your out-of-pocket drug 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 receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than the plan's price

Sometimes when you are in the Deductible stage, you can buy your drug **at a network pharmacy** for a price that is lower than the plan's price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside the plan's 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.
- 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.
- **Please note:** If you are in the Deductible stage, the plan 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.

2. 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 co-payment to the patient assistance program.

- 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.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, the plan 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.

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.

CHAPTER 6: Your rights and responsibilities

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SECTION 1 Our Plan must honor your rights as a member of the Plan

Section 1.1 We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in braille, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are on the front cover).

Our Plan has people and translation services available to answer questions from non-English-speaking members. We can also give you information in braille, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our Plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week and tell them that you want to file a complaint. TTY/TDD users call 1-877-486-2048.

Section 1.2 We must treat you 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, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

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/TDD 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). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered drugs

As a member of our Plan, you also 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, **Chapter 7** of this booklet tells what you can do.

Section 1.4 We must protect the 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.
- 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.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- 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 that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our Plan through Medicare, 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 can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the Plan and to get a copy of your records. 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 consider your request and 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 (phone numbers are on the cover of this booklet).

Section 1.5 We must give you information about the Plan, its network of pharmacies, and your covered drugs

As a member of our Plan, you have the right to get several kinds of information from us. (As explained above in **Section 1.1,** you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in braille or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are on the cover of this booklet):

- **Information about our Plan** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
  - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are on the cover of this booklet) or visit our website at **www.medco.com**.
- **Information about your coverage and rules you must follow in using your coverage**
  - To get the details on your Part D prescription drug coverage, see **Chapters 3 and 4** of this booklet, plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are on the cover of this booklet).
- **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 ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are not happy, or if you 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 7** 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. (**Chapter 7** also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our Plan to pay our share of the cost for a Part D prescription drug, see **Chapter 5** of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that *if you want to*, 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.
- **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 health care** 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.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **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 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 and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

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

Section 1.7 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, **Chapter 7** of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in **Chapter 7,** what you need to do to follow up on a problem or concern depends on the situation. You might need 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—ask for a coverage decision, make an appeal, or make a complaint—**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 (phone numbers are on the cover of this booklet).

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

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/TDD 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

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:

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to **Chapter 2, Section 3.**

Section 1.9 How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to **Chapter 2, Section 3.**
- You can contact **Medicare.**
  - You can visit the Medicare website (http://www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
  - Or you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the Plan

Section 2.1 What are 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 (phone numbers are on the cover of this booklet). We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
  - **Chapters 3 and 4** give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage besides 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.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to 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.
  - 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 these payments:
  - You must pay your plan premiums to continue being a member of our Plan.
  - For some of your drugs covered by the Plan, you must pay your share of the cost when you get the drug. This will be a co-payment (a fixed amount) *or* coinsurance (a percentage of the total cost). **Chapter 4** tells what you must pay for your Part D prescription drugs.
  - 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's important to tell us right away. Call Customer Service (phone numbers are on the cover of this booklet). We need to keep your membership record up to date and know how to contact you.
- **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 cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see **Chapter 2.**

CHAPTER 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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Background

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Please call us first.

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Service (phone numbers are on the cover of this booklet). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our Plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our Plan.

This chapter explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and making appeals.**
- For other types of problems, you need to use the **process for making complaints.**

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in **Section 3** will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses 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.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected to us. You can always contact your **State Health Insurance Assistance Program.** This government program has trained counselors in every state. The program is not connected with our Plan 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. Their services are free. You will find phone numbers in **Chapter 2, Section 3** of this booklet.

You can also get help and information from Medicare

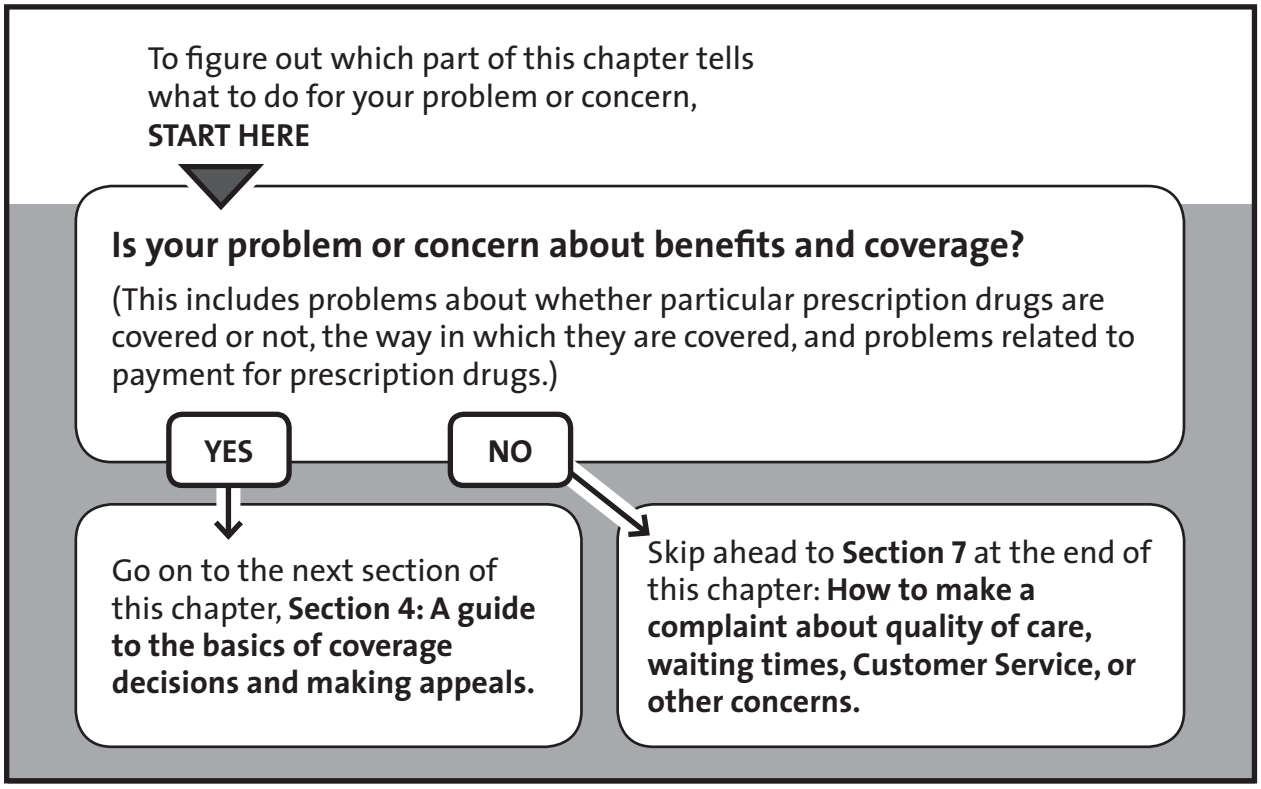
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.



Coverage decisions and appeals

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: The big picture

The process for coverage decisions and making appeals deals with problems 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.

Asking 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 prescription drugs. We make a coverage decision for you whenever you fill a prescription at a pharmacy.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the drug is covered and pay our share of the cost.
- But in some cases, we might decide the 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 being fair and following all of the rules properly. When we have completed the review, we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our Plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are on the cover).
- To **get free help from an independent organization** that is not connected with our Plan, contact your State Health Insurance Assistance Program (see **Section 2** of this chapter).
- **You should consider getting your doctor or other prescriber involved if possible, especially if you want a fast or expedited decision.** In most situations involving a coverage decision or appeal, your doctor or other prescriber must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the Plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about representatives).
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under state law.
    - 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 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.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also 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 appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read **Section 4** of this chapter, **A guide to the basics of coverage decisions and appeals?** If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug, or you want us to pay you back for a Part D drug

Your benefits as a member of our Plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's List of Covered Drugs (Formulary) and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the List of Covered Drugs, rules and restrictions on coverage, and cost information, see **Chapter 3 (Using our plan's coverage for your Part D prescription drugs)** and **Chapter 4 (What you pay for your Part D prescription drugs).**

Part D coverage decisions and appeals

As discussed in **Section 4** of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

> **Legal terms**
>
> A coverage decision is often called an **"initial determination"** or "initial decision." When the coverage decision is about your Part D drugs, the initial determination is called a **"coverage determination."**

Here are examples of coverage decisions you 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 plan's List of Covered Drugs
  - 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 plan's List of Covered Drugs 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.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

Which of these situations are you in?

Request a Coverage Decision:

Do you want to ask us to make an exception to the rules or restrictions on our plan's coverage of a drug?

You can ask us to make an exception. (This is a type of coverage decision.)

Start with **Section 5.2** of this chapter.

Do you want to ask us to cover a drug for you? (For example, if we cover the drug but we require you to get approval from us first.)

You can ask us for a coverage decision.

Skip ahead to **Section 5.4** of this chapter.

Do you want to ask us to pay you back for a drug you have already received and paid for?

You can ask us to pay you back. (This is a type of coverage decision.)

Skip ahead to **Section 5.4** of this chapter.

Make an Appeal:

Has our Plan already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?

You can make an appeal. (This means you are asking us to reconsider).

Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is 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:

1. **Covering a Part D drug for you that is not on our plan's List of Covered Drugs (Formulary).** (We call it the Drug List for short.)

> **Legal terms**
> Asking for coverage of a drug that is not on the Drug List is sometimes called asking for 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 to drugs in our non-preferred brand cost-sharing tier (Tier 3). You cannot ask for an exception to the co-payment or coinsurance amount we require you to pay for the drug.
- You cannot ask for coverage of any "excluded drugs," or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see **Chapter 3.**)

2. **Remove a restriction on the plan's coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on the plan's List of Covered Drugs (for more information, go to **Chapter 3**).

> **Legal terms**
> Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand-name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

- If our Plan agrees to make an exception and waive a coverage restriction for you, you can ask for an exception to the co-payment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the plan's Drug List is in one of *four* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

> **Legal terms**
>
> Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If your drug is in our Non-Preferred Brand-Name Cost-Sharing Tier (Tier 3), you can ask us to cover it at the cost-sharing amount that applies to drugs in our Preferred Brand-Name Cost-Sharing Tier (Tier 2). This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in our Specialty Cost-Sharing Tier (Tier 4).

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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.

Our Plan can say yes or no to your request

- 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. **Section 5.5** tells you how to make an appeal if we say no.

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

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1 **You ask our Plan to make a coverage decision about the drug(s) or payment you need.** If your health requires a quick response, you must ask us to make a **"fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our Plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to **Chapter 2, Section 1** and look for the section called, **How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.** Or, if you are asking us to pay you back for a drug, go to the section called, **Where to send a request that asks us to pay for our share of the cost of a drug you have received.**
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. **Section 4** of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our Plan to pay you back for a drug,** start by reading **Chapter 5** of this booklet: **Asking the Plan to pay its share of the costs for covered drugs. Chapter 5** 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.
- **If you are requesting an exception, provide the doctor's statement.** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our Plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See **Sections 5.2** and **5.3** for more information about exception requests.

If your health requires it, ask us to give you a "fast decision"

Legal terms

A "fast decision" is called an **"expedited decision."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.

- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a *drug you have not yet received.* (You cannot get a fast decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast decision *only* if 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 medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see **Section 7** of this chapter.)

Step 2 Our Plan considers your request and we give you our answer.

Deadlines for a **"fast"** coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. 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. We will give you our answer sooner if your health requires us to.
  - 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. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **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.

Deadlines for a **"standard"** coverage decision

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. 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 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 organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, 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 we approve your request to pay you back for a drug you already bought, we are also required to **send payment to you within 30 calendar days** 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.

Step 3 If we say no to your coverage request, 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.

Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our Plan)

When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."An appeal to the Plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1 You contact our Plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **fast appeal.**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact our Plan.**
  - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to **Chapter 2, Section 1,** and look for the section called, **How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.**
- **Make your appeal in writing by submitting a signed request.** You may also ask for an appeal by calling us at the phone numbers shown in **Chapter 2, Section 1, How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.**
- **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.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal terms	A "fast appeal" is also called an **"expedited appeal."**

- If you are appealing a decision our Plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast decision in **Section 5.4** of this chapter.

Step 2 Our Plan considers your appeal and we give you our answer.

- When our Plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and 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.

Deadlines for a **"fast" appeal**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, 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. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)

- **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.
- **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 **"standard" appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, 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. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide 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.

Step 3 If we say no to your appeal, you decide if you want to continue with the appeals process and 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 (see below).

Section 5.6 Step-by-step: How to make a Level 2 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 go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal terms

The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1 To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- 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 ask us for a copy of your case file.**
- You have the right to give the Independent Review Organization additional information to support your appeal.

Step 2 The Independent Review Organization does a review of your appeal and gives you an answer.

- **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 about your Part D benefits with our Plan.
- 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 for a **"fast" appeal** at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal.
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for a **"standard" appeal** at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - 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 from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

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: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third 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. **Section 6** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

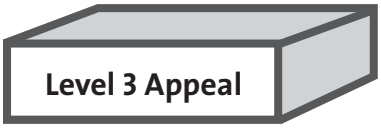
SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D drug appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

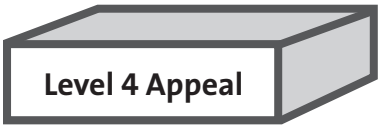
If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.



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."

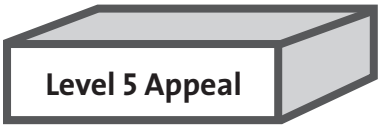
- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your 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 answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal 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. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.



A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

Making complaints

SECTION 7 How to make a complaint about quality of care, waiting times, Customer Service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to **Section 4** of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes 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 kinds of problems, you can make a complaint

Quality of your medical care

- Are you unhappy with the quality of the care you have received?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor Customer Service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how Customer Service has dealt with you?
- Do you feel you are being encouraged to leave our Plan?

Waiting times

- Have you been kept waiting too long by pharmacists? Or by Customer Service or other staff at our Plan?
- Examples include waiting too long on the phone or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a pharmacy?

Information you get from our Plan

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint.

Possible complaints (continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in **Sections 4-6** of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our Plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe our Plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our Plan is told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our Plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for "making a complaint" is "filing a grievance"

Legal terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

Section 7.3 Step-by-step: Making a complaint

Step 1 Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Call us at the numbers listed on the cover of this booklet.
- **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.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:
  - If you have a complaint, you or your representative may call the phone numbers for Part D Grievances (for complaints about Part D drugs) in **Chapter 2.** We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this "**Medco Medicare Prescription Plan** (PDP) Complaints and Grievances."

    If you prefer to state your grievance in writing, please send a grievance form or a letter with as much detail as possible to: Medco Medicare Prescription Plan (PDP), Medco Health Solutions, Inc., Attn: Service Grievance Resolution Team, P.O. Box 639405, Irving, TX 75063-9405. Medco automatically approves requests by the enrollee, or an enrollee's prescribing physician, on behalf of the enrollee, either orally or in writing, for expedited processing for initial determinations and redeterminations.
- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 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.**

Legal terms

What this section calls a **"fast complaint"** is also called a **"fast grievance."**

Step 2 We look into your complaint and give you our 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 days, but we may take up to 44 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 days (44 days total) to answer your complaint.
- **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.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our Plan by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization.** 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). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in **Chapter 2, Section 4** of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our Plan and also to the Quality Improvement Organization.

CHAPTER 8: Ending your membership in the Plan

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SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our Plan

Ending your membership in **Medco Medicare Prescription Plan** (PDP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the Plan. **Section 2** tells you *when* you can end your membership in the Plan.
  - The process for voluntarily ending your membership varies, depending on what type of new coverage you are choosing. **Section 3** tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. **Section 5** tells you about situations when we must end your membership.

If you are leaving our Plan, you must continue to get your Part D prescription drugs through our Plan until your membership ends.

SECTION 2 When can you end your membership in our Plan?

You may end your membership in our Plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the Plan during the Annual Enrollment Period. In certain situations, you may also be eligible to leave the Plan at other times of the year.

TVA retirees (or eligible dependents) may disenroll from this plan at any time. Disenrolling from this plan will cancel prescription drug coverage as well as medical coverage in the TVA-sponsored supplement plan. If a retiree disenrolls from this Plan, coverage for all dependents will also end. Call the TVA Service Center at 1-888-275-8094 with questions about enrolling or disenrolling.

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the Annual Coordinated Election Period). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens every year from November 15 to December 31.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare prescription drug plan
  - Original Medicare *without* a separate Medicare prescription drug plan
  - – or – A Medicare Advantage Plan. A Medicare Advantage Plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (hospital) and Part B (medical) benefits. Some Medicare Advantage Plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare Advantage Plans, you will be disenrolled from **Medco Medicare Prescription Plan** (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service Plan without Part D drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, you can enroll in that plan and keep **Medco Medicare Prescription Plan** (PDP) for your drug coverage. If you do not want to keep our Plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.

    Note: If you disenroll from a Medicare prescription drug plan 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 at least as good as Medicare's standard prescription drug coverage.)
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period, but your plan choices are more limited

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period.**

- **When is the Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the Medicare Advantage Open Enrollment Period?** During this time, you can make *one* change to your health plan coverage. However, you may *not* add or drop prescription drug coverage during this time. Since you are currently enrolled in a Medicare prescription drug plan, this means that you can enroll in:
  - A Medicare Advantage Plan with prescription drug coverage. (A Medicare Advantage Plan

is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (hospital) and Part B (medical) benefits.)

- **Note:** You can also enroll in a Medicare Private Fee-for-Service Plan without prescription drug coverage or a Medicare Cost Plan. But in these cases, you must keep your prescription drug coverage through our Plan.

- **When will your membership end?** Your membership will end on the first day of the month after we get your request to change plans.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of **Medco Medicare Prescription Plan** (PDP) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period.**

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples. For the full list, you can contact the Plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
  - If you have moved out of your plan's service area
  - If you have Medicaid
  - If you are eligible for Extra Help with paying for your Medicare prescriptions
  - If you live in a facility, such as a nursing home
- **When are Special Enrollment Periods?** The enrollment periods vary, depending on your situation.
- **What can you do?** If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare prescription drug plan
  - Original Medicare *without* a separate Medicare prescription drug plan
  - – or – A Medicare Advantage Plan. A Medicare Advantage Plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (hospital) and Part B (medical) benefits. Some Medicare Advantage Plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare Advantage Plans, you will automatically be disenrolled from **Medco Medicare Prescription Plan** (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service Plan without Part D drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, you can enroll in that plan and keep **Medco Medicare Prescription Plan** (PDP) for your drug coverage. If you do not want to keep our Plan, you can choose to enroll in another

Medicare prescription drug plan or to drop Medicare prescription drug coverage.

Note: If you disenroll from a Medicare prescription drug plan 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 at least as good as Medicare's standard prescription drug coverage.)

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your Plan.

Section 2.4 Where can you get more information about when you can end your membership?

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

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can find the information in the "Medicare & You 2010" handbook.
  - Everyone with Medicare receives a copy of "Medicare & You" each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or you can order a printed copy by calling Medicare at the numbers below.
- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our Plan?

Section 3.1 You end your membership by enrolling in another plan

Usually, to end your membership in our Plan, you simply enroll in another Medicare plan during one of the enrollment periods (see **Section 2** for information about the enrollment periods). There are a couple of exceptions:

- One exception is when you want to switch from our Plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact **Medco Medicare Prescription Plan** (PDP) Customer Service and ask to be disenrolled from our Plan.
- Another exception is if you join a Private Fee-for-Service Plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan. In this case, you can enroll in that plan and keep **Medco Medicare Prescription Plan** (PDP) for your drug coverage. If you do

not want to keep our Plan, you can choose to enroll in another Medicare prescription drug plan or to drop your Medicare prescription drug coverage.

The table below explains how you should end your membership in our Plan.

If you would like to switch from our Plan to:	This is what you should do:
• Another Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from **Medco Medicare Prescription Plan** (PDP) when your new plan's coverage begins.
• A Medicare Advantage Plan	• Enroll in the Medicare Advantage Plan. With most Medicare Advantage Plans, you will automatically be disenrolled from **Medco Medicare Prescription Plan** (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service Plan without Part D drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, you can enroll in that new plan and keep **Medco Medicare Prescription Plan** (PDP) for your drug coverage. If you want to leave our Plan, you must *either* enroll in another Medicare prescription drug plan *or* contact Customer Service or Medicare and ask to be disenrolled.

If you would like to switch from our Plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan	• **Contact Customer Service and ask to be disenrolled from the Plan (phone numbers are on the cover of this booklet).** • You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY/TDD users should call 1-877-486-2048.

SECTION 4 Until your membership ends, you must keep getting your drugs through our Plan

Section 4.1 Until your membership ends, you are still a member of our Plan

If you leave **Medco Medicare Prescription Plan** (PDP), it may take time before your membership ends and your new Medicare coverage goes into effect. (See **Section 2.1** for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our Plan.

- **You should 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 service.

SECTION 5 *Medco Medicare Prescription Plan* (PDP) must end your membership in the Plan in certain situations

Section 5.1 When must we end your membership in the Plan?

Medco Medicare Prescription Plan (PDP) must end your membership in the Plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move out of our service area for more than 6 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our Plan and that information affects your eligibility for our Plan.
- If 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.
  - We cannot make you leave our Plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums in a timely fashion.
  - We must notify you in writing before we end your membership.

Where can you get more information?

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

- You can call **Customer Service** for more information (phone numbers are on the cover of this booklet).

Section 5.2 We cannot ask you to leave our Plan for any reason related to your health

What should you do if this happens?

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/TDD users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 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. You can also look in **Chapter 7, Section 7** for information about how to make a complaint.

CHAPTER 9: Legal notices

SECTION 1. Notice about governing law 134

SECTION 2. Notice about nondiscrimination 134

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 Advantage 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.

CHAPTER 10: Definitions of important words

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item, or service you think you should be able to receive. **Chapter 7** explains appeals, including the process involved in making an appeal.

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 co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,550 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.

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 co-payment amounts that a plan may require be paid when specific drugs are received; or (3) any coinsurance amount that must be paid as a percentage of the total amount paid for a drug.

Cost-sharing tier – Every drug on the list of covered drugs is in one of four drug tiers. In general, the higher the drug tier number, 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. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your Plan, that isn't a coverage determination. You need to call or write to your Plan to ask for a formal decision about the coverage if you disagree.

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

Creditable prescription drug coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See **Chapter 2** for information about how to contact Customer Service.

Deductible – The amount you must pay 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).

Evidence of Coverage (EOC) and disclosure information – This document, along with and any 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 sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor 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).

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 cost less than brand-name drugs.

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.

Initial Coverage stage – This is the stage after you have met your deductible and before your total out-of-pocket expenses have reached $4,550.

Late enrollment penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug 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.

Medically necessary – Drugs that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

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 (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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 (hospital) and Part B (medical) benefits. An MA Plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) Plan. 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 Cost Plan – Cost Plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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.

"Medigap" (Medicare Supplement Insurance) policy – Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage. 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 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 health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care 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.

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.

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 health care 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. See **Chapter 2** for information about how to contact the QIO in your state and **Chapter 7** for information about making complaints to the QIO.

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 – Service area is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

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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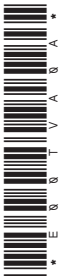

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