



January 1 – December 31, 2012

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of *EnvisionRx Plus Gold PDP*

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

This plan, ***EnvisionRx Plus Gold***, is offered by Envision Insurance Company. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Envision Insurance Company. When it says “plan” or “our plan,” it means ***EnvisionRx Plus Gold***.)

Envision Insurance Company is a Medicare-approved Part D sponsor.

This information is available for free in other languages. Please contact our Member Services number at 1-866-250-2005 for additional information. (TTY users should call 711). Hours are 24 hours a day, 7 days a week. Member Services has free language interpreter services available for non-English speakers.

Esta información está disponible de forma gratuita en otros idiomas, póngase en contacto con nuestro departamento de Servicio al Miembro llamando al 1-866-250-2005 para obtener información adicional. (Los usuarios de TTY deben llamar al 711). El horario es 24 horas del día, 7 días a la semana Servicio al Miembro cuenta con servicios de intérprete de lengua para quienes no hablan inglés.

This information is available in a different format, including Spanish, large print and audio format. Please call Member Services at the number listed above if you need plan information in another format or language.

Esta información puede estar disponible en un formato diferente, incluyendo español, en impresión grande, y en formato de audio. Favor de llamar al servicio al cliente al número en la parte superior, si usted quiere la información en otro formato o lenguaje.

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

S7694_2012 EOC Gold1 File&Use 10032011

2012 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member	1
Tells what it means to be in a Medicare prescription drug plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.	
Chapter 2. Important phone numbers and resources	14
Tells you how to get in touch with our plan (<i>EnvisionRx Plus Gold</i>) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
Chapter 3. Using the plan's coverage for your Part D prescription drugs	25
Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan's <i>List of Covered Drugs (Formulary)</i> to find out which drugs are covered. Tells which kinds of drugs are <i>not</i> covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan's programs for drug safety and managing medications.	
Chapter 4. What you pay for your Part D prescription drugs	45
Tells about the 3 stages of drug coverage (<i>Initial Coverage Period, Coverage Gap Stage, Catastrophic Coverage Stage</i>) and how these stages affect what you pay for your drugs. Explains the 5 cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier. Tells about the late enrollment penalty.	
Chapter 5. Asking us to pay our share of the costs for covered drugs	65

Tells when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered drugs.

Chapter 6. Your rights and responsibilities 71

Explains the rights and responsibilities you have as a member of our plan.
Tells what you can do if you think your rights are not being respected.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)..... 80

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules and/or extra restrictions on your coverage.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

Chapter 8. Ending your membership in the plan..... 105

Tells when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.

Chapter 9. Legal notices..... 114

Includes notices about governing law and about nondiscrimination.

Chapter 10. Definitions of important words 116

Explains key terms used in this booklet.

Chapter 1. Getting started as a member

SECTION 1	Introduction.....	3
Section 1.1	You are enrolled in EnvisionRx Plus Gold , which is a Medicare Prescription Drug Plan.....	3
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?	3
Section 1.3	What does this Chapter tell you?	3
Section 1.4	What if you are new to EnvisionRx Plus Gold ?.....	3
Section 1.5	Legal information about the <i>Evidence of Coverage</i>	4
SECTION 2	What makes you eligible to be a plan member?	4
Section 2.1	Your eligibility requirements.....	4
Section 2.2	What are Medicare Part A and Medicare Part B?.....	4
Section 2.3	Here is the plan service area for EnvisionRx Plus Gold	5
SECTION 3	What other materials will you get from us?.....	5
Section 3.1	Your plan membership card – Use it to get all covered prescription drugs.....	5
Section 3.2	The <i>Pharmacy Directory</i> : Your guide to pharmacies in our network	6
Section 3.3	The plan’s <i>List of Covered Drugs (Formulary)</i>	6
Section 3.4	The <i>Explanation of Benefits</i> (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs	7
SECTION 4	Your monthly premium for EnvisionRx Plus Gold.....	7
Section 4.1	How much is your plan premium?.....	7
Section 4.2	There are several ways you can pay your plan premium.....	9
Section 4.3	Can we change your monthly plan premium during the year?	11
SECTION 5	Please keep your plan membership record up to date.....	11

Section 5.1	How to help make sure that we have accurate information about you	11
SECTION 6	We protect the privacy of your personal health information	12
Section 6.1	We make sure that your health information is protected	12
SECTION 7	How other insurance works with our plan.....	12
Section 7.1	Which plan pays first when you have other insurance?.....	12

SECTION 1 Introduction

Section 1.1	You are enrolled in <i>EnvisionRx Plus Gold</i>, which is a Medicare Prescription Drug Plan
--------------------	--

You are covered by Original Medicare for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, ***EnvisionRx Plus Gold***.

There are different types of Medicare plans. ***EnvisionRx Plus Gold*** is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2	What is the <i>Evidence of Coverage</i> 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.

This plan, ***EnvisionRx Plus Gold***, is offered by Envision Insurance Company. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Envision Insurance Company. When it says “plan” or “our plan,” it means ***EnvisionRx Plus Gold***.)

The word “coverage” and “covered drugs” refers to the prescription drug coverage available to you as a member of ***EnvisionRx Plus Gold***.

Section 1.3	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 is your plan’s service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4	What if you are new to <i>EnvisionRx Plus Gold</i>?
--------------------	--

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 Member Services (contact information is on the back cover of this booklet).

Section 1.5 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 **EnvisionRx Plus Gold** covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in **EnvisionRx Plus Gold** between January 1, 2012 and December 31, 2012.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve **EnvisionRx Plus Gold** 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 institutional providers such as hospitals, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for *EnvisionRx Plus Gold*

Although Medicare is a Federal program, **EnvisionRx Plus Gold** is available only to individuals who live in our plan service area. To remain 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: Alaska, Arkansas, Florida, Hawaii, Illinois, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Wisconsin, and Wyoming.

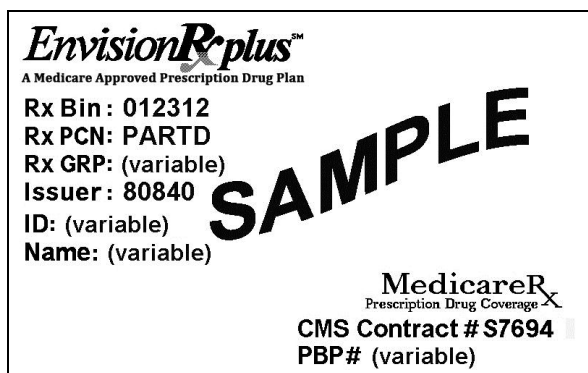
We offer coverage in several states. However, there may be cost or other differences between the plans we offer in each state. If you move out of the state where you live into a state that is still within our service area, you must call Member Services in order to update your information. If you move into a state outside of our service area, you cannot remain a member of our plan. Please call Member Services to find out if we have a plan in your new state.

If you plan to move out of the service area, please contact Member Services. When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

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 your membership card for our plan for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Member Services 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 <i>Pharmacy Directory</i>: Your guide to pharmacies in our network
--------------------	---

Every year that you are a member of our plan, we will send you either a new *Pharmacy Directory* or an update to your *Pharmacy Directory*. This directory lists our network pharmacies.

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.

If you don’t have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.envisionrxplus.com

Section 3.3	The plan’s <i>List of Covered Drugs (Formulary)</i>
--------------------	--

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 **EnvisionRx Plus Gold**. 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 **EnvisionRx Plus Gold** Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Members Services to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan’s website (www.envisionrxplus.com) or call Member Services (phone numbers are on the back cover of this booklet).

Section 3.4 The *Explanation of Benefits* (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the “EOB”).

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D 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 Member Services.

You may also get your *Explanation of Benefits* on our website (www.envisionrxplus.com). Using your assigned EIC Member ID and Medicare ID (HIC#) log in and review your explanation of benefits online or print a copy.

SECTION 4 Your monthly premium for *EnvisionRx Plus Gold*

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each region we serve. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

STATE	Premium	STATE	Premium	STATE	Premium
Alaska	82.50	Arkansas	59.60	Florida	59.80
Hawaii	54.50	Illinois	68.20	Iowa	70.80
Kansas	68.60	Minnesota	70.80	Missouri	67.40
Montana	70.80	Nebraska	70.80	New Mexico	60.00
North Dakota	70.80	Oklahoma	75.10	South Dakota	70.80
Texas	61.20	Wisconsin	78.20	Wyoming	70.80

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, the **information about premiums 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), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, go to Chapter 4, Section 11 of this booklet. You can also visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.
- 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 have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) For these members, the late enrollment penalty is added to the plan’s monthly premium. Their premium amount 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 10 explains the late enrollment penalty.

- If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

Some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B, in addition to paying the monthly Part D plan premium.

- Your copy of *Medicare & You 2012* gives information about these premiums in the section called “2012 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 2012* 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 users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium
--

There are four ways you can pay your plan premium. You can tell us how you want to pay your premium on the enrollment form or on a form we send you with your first premium bill. If you want to change the way you pay your premium, please contact Member Services.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

You may decide to pay your monthly plan premium directly to our plan with a check or money order made payable to **EnvisionRx Plus**. You will be billed on a monthly basis and your payments must be received by the 1st day of each month. You may mail your check or money order to:

EnvisionRx Plus
P.O. Box 1298
Twinsburg, OH 44087
ATTN: Accounting

There will be a \$30 fee assessed for each returned check due to non-sufficient funds.

Option 2: Automatic withdrawal from your bank account

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank account. You will not receive a monthly invoice if you choose this automatic payment option. You will be charged on the third business day of each month. There will be a \$30 fee assessed for any automatic payments that fail due to non-sufficient funds.

Option 3: Direct charge to your debit or credit card

You can also have your monthly plan premium automatically charged directly to your Visa or MasterCard debit or credit card. You will not receive a monthly invoice if you choose one of these automatic payment options. You will be charged on the third business day of each month. There will be a \$30 fee assessed for any automatic payments that fail due to non-sufficient funds.

Option 4: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up.

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

Your plan premium is due in our office by the first day of every month. If we have not received your premium by the 11th, we will send you a notice telling you that your plan membership will end if we do not receive your premium payment within 60 days of the due date.

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. If we end your membership with the plan because you did not pay your 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 you go without "creditable" drug coverage for more than 63 days, you may have to pay a premium penalty when you sign up for a Part D plan.)

If we end your membership because you did not pay your premiums, you will still have coverage under Original Medicare. At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of these premiums. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the late premiums before you can enroll.

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

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 September 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 the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program 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 the Extra Help program in Chapter 2, Section 7.

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 enrollment form, 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.

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
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Member Services (phone numbers are on the back cover of this booklet).

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

That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected
--

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?
--

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

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.

- If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1	<i>EnvisionRx Plus Gold</i> contacts (how to contact us, including how to reach Member Services at the plan)	15
SECTION 2	Medicare (how to get help and information directly from the Federal Medicare program)	18
SECTION 3	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare).....	19
SECTION 4	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)	19
SECTION 5	Social Security	20
SECTION 6	Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)	21
SECTION 7	Information about programs to help people pay for their prescription drugs	21
SECTION 8	How to contact the Railroad Retirement Board	24
SECTION 9	Do you have “group insurance” or other health insurance from an employer?	24

SECTION 1 *EnvisionRx Plus Gold* contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to **EnvisionRx Plus Gold** Member Services. We will be happy to help you.

Member Services	
CALL	1-866-250-2005 Calls to this number are free. Member Services, including TTY, is open 24 hours a day, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The TTY is available 24 hours a day, 7 days a week.
FAX	1-866-250-5178
WRITE	<i>EnvisionRx Plus</i> P.O. Box 1298 Twinsburg, OH 44087 customerservice@envisionrxplus.com
WEBSITE	www.envisionrxplus.com

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making 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)*).

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) 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)*).

Coverage Decisions, Appeals, and Complaints for Part D Prescription Drugs	
CALL	1-866-250-2005 Calls to this number are free. Member Services, including the TTY, is open 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The TTY is open 24 hours a day, 7 days a week.
FAX	1-866-250-5178

WRITE	EnvisionRx Plus P.O. Box 1298 Twinsburg, OH 44087 Attn: Clinical Services customerservice@envisionrxplus.com
WEBSITE	www.envisionrxplus.com

Where to send a request asking 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 us to pay our share of the costs for covered drugs*).

Payment Requests	
CALL	1-866-250-2005. Member Services is open 24 hours a day, 7 days a week. Calls to this number are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The TTY is open 24 hours a day, 7 days a week.
FAX	1-866-250-5178
WRITE	EnvisionRx Plus P.O. Box 1298 Twinsburg, OH 44087 Attn: Clinical Services
WEBSITE	www.envisionrxplus.com

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	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. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.” The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance)

policies in your area. Select “Health & Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

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 number 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. You can find the name of your state SHIP in Appendix A at the end of this document.

A 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.

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. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

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 for each state. You can find the name of your state’s Quality Improvement Organization in Appendix B at the end of this document.

A 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. A Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact the Quality Improvement Organization if you have a complaint about the quality of care you have received. For example, you can contact the Quality Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

The Social Security Administration 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. 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 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	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 am ET to 7:00 pm, 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.

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

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

To find out more about Medicaid and its programs, contact your state’s Medicaid agency listed at the end of this document in Appendix C.

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, and prescription copayments 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.

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

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

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 copayment level, or, if you already have the evidence, to provide this evidence to us.

- For assistance obtaining evidence of your proper cost-sharing level, please contact Member Services. We may be able to help you identify the documentation you need. Once you have obtained the proper evidence, you may mail or fax the documentation to our Member Services department for processing.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment 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 Member Services if you have questions.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program is available nationwide. Because **EnvisionRx Gold** offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 4, Section 6 for more information about your coverage during the Coverage Gap Stage.

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

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 14% of the price for generic drugs and you pay the remaining 86% of the price. The coverage for

generic drugs works differently than the 50% discount for brand name drugs. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

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

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

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

State Pharmaceutical Assistance 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.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. You can find out if your state has a State Pharmaceutical Assistance Program by looking in Appendix D at the end of this document.

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 am to 3:30 pm, 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	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 <i>not</i> free.
WEBSITE	http://www.rrb.gov

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group, call the employer/union benefits administrator or Member Services 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

SECTION 1	Introduction	27
Section 1.1	This chapter describes your coverage for Part D drugs	27
Section 1.2	Basic rules for the plan's Part D drug coverage	28
SECTION 2	Fill your prescription at a network pharmacy or through the plan's mail-order service	28
Section 2.1	To have your prescription covered, use a network pharmacy	28
Section 2.2	Finding network pharmacies.....	28
Section 2.3	Using the plan's mail-order services.....	29
Section 2.4	How can you get a long-term supply of drugs?	30
Section 2.5	When can you use a pharmacy that is not in the plan's network?	30
SECTION 3	Your drugs need to be on the plan's "Drug List"	31
Section 3.1	The "Drug List" tells which Part D drugs are covered	31
Section 3.2	There are 5 "cost-sharing tiers" for drugs on the Drug List	31
Section 3.3	How can you find out if a specific drug is on the Drug List?.....	32
SECTION 4	There are restrictions on coverage for some drugs	32
Section 4.1	Why do some drugs have restrictions?	32
Section 4.2	What kinds of restrictions?	33
Section 4.3	Do any of these restrictions apply to your drugs?.....	33
SECTION 5	What if one of your drugs is not covered in the way you'd like it to be covered?	34
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	34

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?.....	35
Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?.....	37
SECTION 6	What if your coverage changes for one of your drugs?.....	38
Section 6.1	The Drug List can change during the year.....	38
Section 6.2	What happens if coverage changes for a drug you are taking?.....	38
SECTION 7	What types of drugs are <i>not</i> covered by the plan?.....	39
Section 7.1	Types of drugs we do not cover.....	39
SECTION 8	Show your plan membership card when you fill a prescription	40
Section 8.1	Show your membership card	40
Section 8.2	What if you don't have your membership card with you?.....	41
SECTION 9	Part D drug coverage in special situations	41
Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?.....	41
Section 9.2	What if you're a resident in a long-term care facility?	41
Section 9.3	What if you are taking drugs covered by Original Medicare?.....	42
Section 9.4	What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?.....	42
Section 9.5	What if you're also getting drug coverage from an employer or retiree group plan?.....	43
SECTION 10	Programs on drug safety and managing medications	43
Section 10.1	Programs to help members use drugs safely.....	43
Section 10.2	Programs to help members manage their medications	44



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 about the costs for Part D prescription drugs 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 Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

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*.) Your Part D prescription drugs are covered under our plan. 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 have a provider (a doctor or other prescriber) write your prescription.
- 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 used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-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 on the plan's Drug List.

Section 2.2	Finding network pharmacies
--------------------	-----------------------------------

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.envisionrxplus.com), or call Member Services (phone numbers are on the back cover of this booklet). 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 either to have a new prescription written by a provider 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 Member Services (phone numbers are on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.envisionrxplus.com.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. The Infusion drugs must be covered under Medicare Part D.
- 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 Member Services. Prescriptions for formulary drugs are available up to 31 days in these types of pharmacies.
- 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 drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services.

Section 2.3	Using the plan's mail-order services
--------------------	---

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail please call Member Services. 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 14 days. If your mail-order is delayed, you will be able to receive a temporary supply at your local pharmacy. Please contact Member Services at 1-866-250-2005, 24 hours a day, 7 days a week for more information.

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 may agree to accept the mail-order cost-sharing amount for a long-term supply of mail-order drugs. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for a long-term 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 Member Services for more information.
2. You can use the plan’s network **mail-order services**. Our plan’s mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

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

Your prescription may 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:

- If there are no participating pharmacies near you, we will cover prescriptions filled at an out-of-network pharmacy in the event of an emergency only.

In these situations, **please check first with Member Services** 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 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 use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

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

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually 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 5 "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 drugs are preferred generic drugs

- Tier 2 drugs are non-preferred generic drugs
- Tier 3 drugs are preferred brand drugs
- Tier 4 drugs are non-preferred brand drugs
- Tier 5 drugs are specialty drugs

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 3 ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Members Services to find out if we cover it.)
2. Visit the plan's website (www.envisionrxplus.com). The Drug List on the website is always the most current.
3. Call Member Services 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 Member Services are on the back cover of this booklet.

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 to get a drug that works for your medical condition and is safe and effective. 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 provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for

you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Section 5.2 for information about asking for exceptions.)

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.

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider 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 provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. 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 Member Services (phone numbers are on the back cover of this booklet) or check our website (www.envisionrxplus.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Section 5.2 for information about asking for exceptions.)

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 provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** 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. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **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 5 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). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- 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.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- 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 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 a 30-day supply, 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 reside in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **For those members who are outside their transition period and experience a change in the level of care when changing from one treatment setting to another (example: long-term care facility to hospital, hospital to long-term care facility, hospital to home, home to long-term care facility):**

Upon admission or discharge from a treatment setting or long-term care facility, we will allow you access to a 30-day supply of your drug from a retail setting or a 31-day supply from a long-term care setting for formulary medications and an emergency transition fill for non-formulary medications (including Part D covered drugs that are on our formulary but require prior authorization or step therapy).

This policy does not apply for short-term leaves of absences (i.e. holidays or vacations) from LTC or hospital facilities.

To the extent that a member is outside his or her 90-day transition period, and is in the outpatient setting, we will still provide an emergency 30-day supply of Part D covered non-formulary medications (including Part D covered drugs that are on our formulary that would otherwise require prior authorization or step therapy under our utilization management rules), on a case by case basis, while an exception request is being processed.

To the extent that a member is outside his or her 90-day transition period, and is in long-term care facility, we will still provide an emergency 31-day supply of Part D covered non-formulary medications (including Part D covered drugs that are on our formulary that would otherwise require prior authorization or step therapy under our utilization management rules), while an exception request is being processed.

To ask for a temporary supply, call Member Services (phone numbers are on the back cover of this booklet).

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

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs

that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 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

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

For drugs in Tier 2 and Tier 4, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 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.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Tier 1, Tier 3 or Tier 5.

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 provider 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 provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your provider will also know about this change, and can work with you to find another drug for your condition.

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.” This means Medicare does not pay for these drugs.

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. 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 it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7, Section 5.5 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.

- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- 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. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

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 Original Medicare?
--------------------	--

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 when 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 Member Services.

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 a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

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 provider 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 provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

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

Your enrollment in **EnvisionRx Plus Gold** 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 **EnvisionRx Plus Gold** 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 **EnvisionRx Plus Gold** 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 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 is expected to pay, on average, at least as much as Medicare's standard prescription 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 Medigap 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?
--------------------	--

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 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 the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription 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 provider 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 you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are on the back cover of this booklet).

Chapter 4. What you pay for your Part D prescription drugs

SECTION 1	Introduction.....	47
Section 1.1	Use this chapter together with other materials that explain your drug coverage	47
SECTION 2	What you pay for a drug depends on which “drug payment stage” you are in when you get the drug	48
Section 2.1	What are the drug payment stages for <i>EnvisionRx Plus Gold</i> members?.....	48
SECTION 3	We send you reports that explain payments for your drugs and which payment stage you are in	49
Section 3.1	We send you a monthly report called the “Explanation of Benefits” (the “EOB”)	49
Section 3.2	Help us keep our information about your drug payments up to date.....	50
SECTION 4	There is no deductible for <i>EnvisionRx Plus Gold</i>.....	51
Section 4.1	You do not pay a deductible for your Part D drugs.	51
SECTION 5	During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share	51
Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription	51
Section 5.2	A table that shows your costs for a <i>one-month</i> supply of a drug.....	52
Section 5.3	A table that shows your costs for a <i>long-term</i> (90-day) supply of a drug	53
Section 5.4	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2,930	54
SECTION 6	During the Coverage Gap Stage, the plan provides some drug coverage.....	55
Section 6.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700	55

Section 6.2	How Medicare calculates your out-of-pocket costs for prescription drugs.....	56
SECTION 7	During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs	58
Section 7.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year	58
SECTION 8	Additional benefits information	58
Section 8.1	Our plan offers additional benefits	58
SECTION 9	What you pay for vaccinations covered by Part D depends on how and where you get them	58
Section 9.1	Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot	58
Section 9.2	You may want to call us at Member Services before you get a vaccination	60
SECTION 10	Do you have to pay the Part D “late enrollment penalty”?	60
Section 10.1	What is the Part D “late enrollment penalty”?	60
Section 10.2	How much is the Part D late enrollment penalty?	61
Section 10.3	In some situations, you can enroll late and not have to pay the penalty	61
Section 10.4	What can you do if you disagree about your late enrollment penalty?.....	62
SECTION 11	Do you have to pay an extra Part D amount because of your income?	63
Section 11.1	Who pays an extra Part D amount because of income?	63
Section 11.2	How much is the extra Part D amount?	63
Section 11.3	What can you do if you disagree about paying an extra Part D amount?.....	64



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* about the costs for Part D prescription drugs 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), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

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, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage 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 5 “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 Member Services (phone numbers are on the back cover of this booklet). You can also find the Drug List on our website at www.envisionrxplus.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. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month's 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 drug payment stages for <i>EnvisionRx Plus Gold</i> members?

As shown in the table below, there are “drug payment stages” for your prescription drug coverage under **EnvisionRx Plus Gold**. 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 <i>Yearly Deductible Stage</i>	Stage 2 <i>Initial Coverage Stage</i>	Stage 3 <i>Coverage Gap Stage</i>	Stage 4 <i>Catastrophic Coverage Stage</i>
<p>Because there is no deductible for the plan, this payment stage does not apply to you.</p>	<p>You begin in this stage when you fill your first prescription of the year.</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$2,930.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>For generic drugs, you pay either a \$2 copayment or 86% of the costs, whichever is lower. For brand name drugs, you pay 50% of the price (plus the dispensing fee).</p> <p>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$4,700. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2012).</p> <p>(Details are in Section 7 of this chapter.)</p>

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” (the “EOB”)

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 through the plan during the previous month. 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 keep track of your out-of-pocket costs. 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.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time 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.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health

Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) 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 Member Services (phone numbers are on the back cover of this booklet). You can also view or print your EOB from our website at www.envisionrxplus.com by selecting and logging in under the “I Am A Member” section at the top of the web page. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for *EnvisionRx Plus Gold*

Section 4.1 You do not pay a deductible for your Part D drugs.
--

There is no deductible for ***EnvisionRx Plus Gold***. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in 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 copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 5 Cost-Sharing Tiers

Every drug on the plan’s Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing Tier 1 includes preferred generic drugs
- Cost-Sharing Tier 2 includes non-preferred generic drugs
- Cost-Sharing Tier 3 includes preferred brand drugs
- Cost-Sharing Tier 4 includes non-preferred brand drugs
- Cost-Sharing Tier 5 includes 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 <i>one-month</i> supply of a drug
--------------------	--

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

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

As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

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

	Network pharmacy (up to a 30-day supply)	The plan's mail-order service (up to a 30-day supply)	Network long-term care pharmacy (up to a 31-day supply)	Out-of-network pharmacy (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$2	\$2	\$2	100%
Cost-Sharing Tier 2 (Non-Preferred Generic Drugs)	15%	15%	15%	100%
Cost-Sharing Tier 3 (Preferred Brand Drugs)	15%	15%	15%	100%
Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)	30%	30%	30%	100%
Cost-Sharing Tier 5 (Specialty Drugs)	33%	33%	33%	100%

Section 5.3 A table that shows your costs for a *long-term* (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. A long-term supply is 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.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:

	Network pharmacy (90-day supply)	The plan's mail-order service (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$6	\$6
Cost-Sharing Tier 2 (Non-Preferred Generic Drugs)	15%	15%
Cost-Sharing Tier 3 (Preferred Brand Drugs)	15%	15%
Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)	30%	30%
Cost-Sharing Tier 5 (Specialty Drugs)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Section 5.4	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2,930
--------------------	--

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

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

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:

- The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The *Explanation of Benefits* (EOB) 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 \$2,930 limit in a year.

We will let you know if you reach this \$2,930 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, the plan provides some drug coverage

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 50% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay either a \$2 copayment or no more than 86% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and either a \$2 copayment or no more than 86% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2012, that amount is \$4,700.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$4,700, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 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 Initial Coverage Stage.
 - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different 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, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$4,700 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage 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 you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's 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 Member Services to let us know (phone numbers are on the back cover of this booklet).

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

- **We will help you.** The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,700 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 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 \$4,700 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - *–either–* coinsurance of 5% of the cost of the drug
 - *–or–* \$2.60 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.50 copayment for all other drugs.
- **Our plan pays the rest** of the cost.

SECTION 8 Additional benefits information

Section 8.1	Our plan offers additional benefits
--------------------	--

No additional benefits are offered under this plan.

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1	Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot
--------------------	--

Our plan provides coverage of a number of Part D 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 Part D vaccination?

What you pay for a Part D 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 (Formulary)*.
 - Other vaccines are considered medical benefits. They are covered under Original Medicare.
- 2. Where you get the vaccine medication.**
- 3. Who gives you the vaccination shot.**

What you pay at the time you get the Part D 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 Part D vaccination shot. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D 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 coinsurance for the vaccine and administration of the vaccine.

Situation 2: You get the Part D 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 us to pay our share of the costs for covered drugs*).
- You will be reimbursed the amount you paid less your normal coinsurance for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the Part D 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 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 for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Section 9.2	You may want to call us at Member Services 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 Member Services whenever you are planning to get a vaccination (phone numbers are on the back 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 10 **Do you have to pay the Part D “late enrollment penalty”?**

Section 10.1	What is the Part D “late enrollment penalty”?
---------------------	--

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

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. (“Creditable prescription drug coverage” is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable

prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

The penalty is added to your monthly premium. When you first enroll in **EnvisionRx Plus Gold**, we let you know the amount of the penalty.

Your late enrollment penalty is considered part of your plan premium. If you do not pay your late enrollment penalty, you could be disenrolled for failure to pay your plan premium.

Section 10.2 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 example, if you go 14 months without coverage, the penalty 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 2012, this average premium amount is \$31.08.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times \$31.08, which equals \$4.35. This rounds to \$4.40. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

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

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

Section 10.3 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:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. Medicare calls this “**creditable drug coverage.**” Please note:
 - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
 - Please note: If you receive a “certificate of creditable coverage” when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had “creditable” prescription drug coverage that expected to pay as much as Medicare’s standard prescription drug plan pays.
 - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
 - For additional information about creditable coverage, please look in your *Medicare & You* 2012 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

Section 10.4	What can you do if you disagree about your late enrollment penalty?
---------------------	--

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

Important: Do not stop paying your late enrollment penalty while you’re waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 11 Do you have to pay an extra Part D amount because of your income?

Section 11.1 Who pays an extra Part D amount because of income?

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

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

Section 11.2 How much is the extra Part D amount?

If your modified adjusted gross income as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2010 was:	If you were married but filed a separate tax return and your income in 2010 was:	If you filed a joint tax return and your income in 2010 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$11.60
Greater than \$107,000 and less		Greater than \$214,000 and less	\$29.90

If you filed an individual tax return and your income in 2010 was:	If you were married but filed a separate tax return and your income in 2010 was:	If you filed a joint tax return and your income in 2010 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
than or equal to \$160,000		than or equal to \$320,000	
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.10
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$66.40

Section 11.3 What can you do if you disagree about paying an extra Part D amount?

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

Chapter 5. Asking us to pay our share of the costs for covered drugs

SECTION 1	Situations in which you should ask us to pay our share of the cost of your covered drugs	66
Section 1.1	If you pay our plan’s share of the cost of your covered drugs, you can ask us for payment	66
SECTION 2	How to ask us to pay you back.....	67
Section 2.1	How and where to send us your request for payment.....	67
SECTION 3	We will consider your request for payment and say yes or no	68
Section 3.1	We check to see whether we should cover the drug and how much we owe.....	68
Section 3.2	If we tell you that we will not pay for all or part of the drug, you can make an appeal.....	68
SECTION 4	Other situations in which you should save your receipts and send copies to us	69
Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs	69

SECTION 1 Situations in which you should ask us 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).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

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. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Sec. 2.5 to learn more.)

- 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. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request.
- Send a copy of your receipts to us when you ask us to pay you back.
- You should ask for payment for your out-of-pocket expenses (not for any expenses paid by other insurance).
- You have 90 days from the date you enroll in the plan to request payment for drugs you paid for since your retroactive effective date. Your reimbursement will be based on network pharmacy rates. If you went to an out-of-network pharmacy, you may be responsible for the difference.

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 will help us process the information faster.
- Either download a copy of the form from our website (www.envisionrxplus.com) or call Member Services and ask for the form. The phone numbers for Member Services are on the back cover of this booklet.

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

EnvisionRx Plus
P.O. Box 1298
Twinsburg, OH 44087
Attn: Clinical Services

You must submit your claim to us within 90 days of the date you received the service, item, or drug.

Please be sure to contact Member Services if you have any questions. If you don't know what you should have paid, 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 make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- 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 all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, 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 formal 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 5.5 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 copies to us

Section 4.1 In some cases, you should send copies of your receipts to us 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 copies of 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 our price

Sometimes when you are in the Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- 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 Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of 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 copayment 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, we will not pay for any share of these drug costs. But sending a copy of 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

SECTION 1	Our plan must honor your rights as a member of the plan.....	72
Section 1.1	We must provide information in a way that works for you (Spanish, large print, or audio format).....	72
Section 1.2	We must treat you with fairness and respect at all times.....	72
Section 1.3	We must ensure that you get timely access to your covered drugs.....	73
Section 1.4	We must protect the privacy of your personal health information.....	73
Section 1.5	We must give you information about the plan, its network of pharmacies, and your covered drugs.....	74
Section 1.6	We must support your right to make decisions about your care.....	75
Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made.....	76
Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected?.....	77
Section 1.9	How to get more information about your rights.....	77
SECTION 2	You have some responsibilities as a member of the plan.....	78
Section 2.1	What are your responsibilities?.....	78

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 (Spanish, large print, or audio format)

To get information from us in a way that works for you, please call Member Services (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members, such as members who speak Spanish. We can also give you information in large print or audio format if you need it. If you are eligible for Medicare because of a 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 a 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 users call 1-877-486-2048.

Sección 1.1 Debemos proveer información de una manera que funcione para usted (En español, letra grande, o formato audio)

Para obtener información de nosotros de una manera que funcione para usted, por favor llame a Servicios para Miembros (los números están en la contraportada de este folleto).

Nuestro plan tiene personas y servicios gratuitos de intérprete de lenguaje disponible para responder a las preguntas de miembros que no hablan inglés, por ejemplo miembros que solo hablan español. También le podemos proveer información en letra grande o en formato de audio si lo necesita. Si usted es elegible para Medicare debido a una discapacidad, estamos obligados a darle información sobre los beneficios del plan que sea accesible y apropiado para usted.

Si tiene problemas para obtener información de nuestro plan debido a problemas relacionados con el idioma o una discapacidad, por favor llame a Medicare al 1-800-MEDICARE (1-800-633-4227), 24 horas al día, 7 días a la semana, y dígales que usted desea presentar una queja. Los usuarios de TTY pueden llamar al 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, ethnicity, national origin, religion, gender, age, mental or

physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services 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, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, Chapter 7, Section 4 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 Practice," 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. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are on the back cover of this booklet).

In order to release information we require a written request from the member or their Power of Attorney or Legal Representative.

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 Spanish, in large print, or audio format.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the back 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 Member Services (phone numbers are on the back cover of this booklet) or visit our website at www.envisionrxplus.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 (Formulary)*, 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 Member Services (phone numbers are on the back 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. You can ask us to change the decision by making an appeal. 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 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 appropriate state-specific agency as listed in Appendix E.

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 Member Services (phone numbers are on the back 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 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 Member Services** (phone numbers are on the back 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.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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 Member Services** (phone numbers are on the back 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 to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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 Member Services (phone numbers are on the back 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 in addition to our plan, you are required to tell us.** *Please call Member Services 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. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **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.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Pay what you owe.** *As a plan member, you are responsible for these payments:*
 - You must pay your plan premiums to continue being a member of our plan.

-
- For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (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.
 - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
 - **Tell us if you move.** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the back cover of this booklet).*
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - **Call member services 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 Member Services are on the back 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)

BACKGROUND

SECTION 1	Introduction.....	82
Section 1.1	What to do if you have a problem or concern.....	82
Section 1.2	What about the legal terms?.....	82
SECTION 2	You can get help from government organizations that are not connected with us	83
Section 2.1	Where to get more information and personalized assistance.....	83
SECTION 3	To deal with your problem, which process should you use?	83
Section 3.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?.....	83
SECTION 4	A guide to the basics of coverage decisions and appeals.....	85
Section 4.1	Asking for coverage decisions and making appeals: the big picture	85
Section 4.2	How to get help when you are asking for a coverage decision or making an appeal	86
SECTION 5	Your Part D prescription drugs: How to ask for a coverage decision or make an appeal.....	87
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	87
Section 5.2	What is an exception?	89
Section 5.3	Important things to know about asking for exceptions.....	90
Section 5.4	Step-by-step: How to ask for a coverage decision, including an exception.....	91

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)	94
Section 5.6	Step-by-step: How to make a Level 2 Appeal	96
SECTION 6	Taking your appeal to Level 3 and beyond.....	98
Section 6.1	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals.....	98
SECTION 7	How to make a complaint about quality of care, waiting times, customer service, or other concerns.....	100
Section 7.1	What kinds of problems are handled by the complaint process?.....	100
Section 7.2	The formal name for “making a complaint” is “filing a grievance”	102
Section 7.3	Step-by-step: Making a complaint	103
Section 7.4	You can also make complaints about quality of care to the Quality Improvement Organization	104

BACKGROUND

SECTION 1 Introduction

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

This chapter explains two types of processes for handling problems and concerns:

- 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 simpler 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.

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 with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find SHIP phone numbers in Appendix A 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 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, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes.

My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and making appeals.”**

No.

My problem is not about benefits or coverage.

Skip ahead to **Section 7** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

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 are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not 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 Member Services** (phone numbers are on the back cover of this booklet).
- **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).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **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 Member Services and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at www.envisionrxplus.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us 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 the use of the drug is a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

- **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 (Formulary)*, 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	An initial coverage decision about your Part D drugs 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 (Formulary)*
 - 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 (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- 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 the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
<p>Do you need a drug that isn’t on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with Section 5.2 of this chapter.</p>	<p>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to Section 5.4 of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to Section 5.4 of this chapter.</p>	<p>Have we 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?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to Section 5.5 of this chapter.</p>

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 us 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 *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 Tier 4 for brand name drugs or for generic drugs. You cannot ask for an exception to the copayment 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. Removing a restriction on our coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (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 we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment 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 our Drug List is in one of 5 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 Non-Preferred Brand Drug Tier (Tier 4), or the Non-Preferred Generic Drug Tier (Tier 2), you can ask us to cover it at the cost-sharing amount that applies to drugs in Preferred Brand Drug Tier (Tier 3), or the Preferred Generic Drug Tier (Tier 1). 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 Specialty Drug Tier (Tier 5)

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 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.

We 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 us 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 us 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 about your Part D prescription drugs, or when you are making an appeal or complaint 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 asking us to pay for our share of the cost for 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 us to pay you back for a drug,** start by reading Chapter 5 of this booklet: *Asking us to pay our 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 us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. 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 coverage determination. ”
--------------------	---

- 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 are 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), we 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: We consider 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 about a drug you have not yet received*

- 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 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 about payment for a drug you have already bought*

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent 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 are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say 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)

Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”
--------------------	---

Step 1: You contact us 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, your doctor, or your representative, must contact us.**
 - For details on how to reach us by phone, fax, or mail 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 about your Part D prescription drugs, or when you are making an appeal or complaint about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1. (*How to contact us when you are asking for a coverage decision about your Part D prescription drugs, or when you are making an appeal or complaint about your Part D prescription drugs.*)
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (*How to contact us when you are asking for a coverage decision about your Part D prescription drugs, or when you are making an appeal or complaint 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. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **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. We are allowed to charge a fee for copying and sending this information to you.

- If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms	A “fast appeal” is also called an “ expedited redetermination. ”
--------------------	---

- If you are appealing a decision we 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: We consider 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 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 after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

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 you believe your health requires it, you should ask for “fast” appeal.
 - 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.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a 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 independent organization that is hired by Medicare.** This organization is not connected with us 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 us.
- 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 “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 “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 the dollar value that must be in dispute 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.

Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”
--

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

Level 4 Appeal The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
--

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

Level 5 Appeal A judge at the Federal District Court will review your appeal.

- This is the last step of the 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 our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Have you been kept waiting too long by pharmacists? Or by our Member Services or other staff at the 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 us

- 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 us for a coverage decision or made an appeal, and you think that we are 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 we are 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 we are 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 we do 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 Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-866-250-2005, TTY 711, 24 hours a day, 7 days a week.
- **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 put your complaint in writing, put your complaint in writing, we will respond to your complaint in writing.
- Grievances can be filed orally by calling 1-866-250-2005 (TTY users should call 711) or in writing to EnvisionRx Plus, P.O. Box 1298, Twinsburg, OH 44087, Attn: Grievances. In the event you are filing an expedited grievance about a decision to not conduct an expedited coverage determination or redetermination, please call Customer Service at 1-866-250-2005 (TTY users should call 711) and state you are filing a grievance regarding a decision not to conduct an expedited coverage determination or redetermination. We will respond to you within 24 hours on an expedited grievance.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a “fast complaint” is also called an “expedited 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 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **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 us 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 us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work 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 us and also to the Quality Improvement Organization.

Chapter 8. Ending your membership in the plan

SECTION 1	Introduction.....	106
Section 1.1	This chapter focuses on ending your membership in our plan	106
SECTION 2	When can you end your membership in our plan?.....	106
Section 2.1	Usually, you can end your membership during the Annual Enrollment Period	106
Section 2.2	In certain situations, you can end your membership during a Special Enrollment Period	107
Section 2.3	Where can you get more information about when you can end your membership?.....	109
SECTION 3	How do you end your membership in our plan?.....	109
Section 3.1	Usually, you end your membership by enrolling in another plan.....	109
SECTION 4	Until your membership ends, you must keep getting your drugs through our plan	111
Section 4.1	Until your membership ends, you are still a member of our plan.....	111
SECTION 5	<i>EnvisionRx Plus Gold</i> must end your membership in the plan in certain situations.....	112
Section 5.1	When must we end your membership in the plan?.....	112
Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health.....	113
Section 5.3	You have the right to make a complaint if we end your membership in our plan	113

SECTION 1 Introduction

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

Ending your membership in **EnvisionRx Plus Gold** 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.

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 from October 15 to December 7 in 2011.
- **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.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- – *or* – A Medicare health plan. A Medicare health 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 health plans also include Part D prescription drug coverage.
 - If you enroll in most Medicare health plans, you will be disenrolled from **EnvisionRx Plus Gold** 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 **EnvisionRx Plus Gold** 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 drop Medicare prescription drug coverage.

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

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

Section 2.2	In certain situations, you can end your membership during a Special Enrollment Period
--------------------	--

In certain situations, members of **EnvisionRx Plus Gold** 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 we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are on the back cover of this booklet).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
 - **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. 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.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
 - – *or* – A Medicare health plan. A Medicare health 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 health plans also include Part D prescription drug coverage.
 - If you enroll in most Medicare health plans, you will automatically be disenrolled from **EnvisionRx Plus Gold** 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 **EnvisionRx Plus Gold** 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 Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the

coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

- **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 2.3	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 Member Services** (phone numbers are on the back cover of this booklet).
- You can find the information in the *Medicare & You 2012* 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 number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 **How do you end your membership in our plan?**

Section 3.1	Usually, 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). However, there are two situations in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep **EnvisionRx Plus Gold** 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 ask to be disenrolled from our plan.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Member Services if you need more information on how to do this.)
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 4, Section 10 for more information about the late enrollment penalty.

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:
<ul style="list-style-type: none"> • Another Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. <p>You will automatically be disenrolled from EnvisionRx Plus Gold when your new plan’s coverage begins.</p>
<ul style="list-style-type: none"> • A Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the Medicare health plan. <p>With most Medicare health plans, you will automatically be disenrolled from EnvisionRx Plus Gold when your new plan’s coverage begins.</p> <p>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</p>

If you would like to switch from our plan to:	This is what you should do:
<p>that new plan and keep EnvisionRx Plus Gold for your drug coverage. If you want to leave our plan, you must <i>either</i> enroll in another Medicare prescription drug plan <i>or</i> ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact Member Services if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).</p>	
<ul style="list-style-type: none">• Original Medicare <i>without</i> a separate Medicare prescription drug plan.<ul style="list-style-type: none">○ 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. See Chapter 4, Section 10 for more information about the late enrollment penalty.	<ul style="list-style-type: none">• Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet).• You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY 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 **EnvisionRx Plus Gold**, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 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 services.

SECTION 5 *EnvisionRx Plus Gold* must end your membership in the plan in certain situations

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

***EnvisionRx Plus Gold* 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 12 months.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- 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 for 60 days or for two consecutive calendar months..
 - We must notify you in writing that you have a 60 day grace period to pay the plan premium 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 **Member Services** for more information (phone numbers are on the back cover of this booklet).

Section 5.2	We <u>cannot</u> 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 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	115
SECTION 2	Notice about nondiscrimination	115
SECTION 3	Notice about third-party liability	115

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

SECTION 3 Notice about third-party liability

Right of Subrogation

You explicitly acknowledge *EnvisionRx Plus's* right of subrogation. If prescription drug benefits are provided to you by *EnvisionRx Plus* for injuries or illness for which another party is or may be responsible, then *EnvisionRx Plus* reserves the right to reimbursement for the full cost of all prescription drug benefits provided by *EnvisionRx Plus* on your behalf that are associated with the injury or illness for which another party is or may be responsible. When *EnvisionRx Plus* provides prescription drug benefits for injuries or illnesses for which another party is or may be responsible, *EnvisionRx Plus* shall be subrogated to your rights of recovery against any party to the extent of the full cost of all benefits provided by *EnvisionRx Plus* and may proceed against any party with or without your consent.

Right of Reimbursement

You explicitly acknowledge *EnvisionRx Plus's* right of reimbursement. If prescription drug benefits are provided to you by *EnvisionRx Plus* for injuries or illness for which another party is or may be responsible and you and/or your representative has recovered any amounts from another party or any party making payments on the party's behalf, then *EnvisionRx Plus* is hereby granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by *EnvisionRx Plus*. This Right of Reimbursement is cumulative with and not exclusive of *EnvisionRx Plus's* Right of Subrogation, and *EnvisionRx Plus* may choose to exercise either or both rights of recovery.

Chapter 10. Definitions of important words

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

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

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

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

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

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

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. 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. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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 pay, 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.

Deductible – The amount you must pay for prescriptions before our plan begins to pay.

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan 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).

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

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

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

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

Initial Coverage Stage – This is the stage before your total drug expenses have reached \$2,930, including amounts you’ve paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you’re eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected 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. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without “creditable” prescription drug coverage.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered 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 – See “Extra Help.”

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

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). People

with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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 – A Medicare Cost Plan is 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 Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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. 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).

Member Services – 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 Member Services.

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.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are on the back cover of this booklet).

Part C – see “**Medicare Advantage (MA) Plan.**”

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

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

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

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) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

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

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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.

Appendix A - State Health Insurance Assistance Programs

Alabama State Health Insurance Assistance Program (SHIP) 770 Washington Ave., Ste 470 Montgomery, AL 36130 Phone: (800) 243-5463 TTY: (800) 548-2547	Alaska Alaska State Health Insurance Assistance Program (SHIP) 3601 C St, Ste 310 Anchorage, AK 99503 Phone: (907) 269-3680 TTY: (907) 269-3691	Arizona Arizona State Health Insurance Assistance Program 1789 W. Jefferson St., #950a Phoenix, AZ 85007 Phone: (800) 432-4040	Arkansas Senior Health Insurance Information Program (SHIIP) 1200 W 3rd St Little Rock, AR 72201 Phone: (800) 224-6330
California Health Insurance Counseling and Advocacy Program (HICAP) 1300 National Dr Ste 200 Sacramento, CA 95834 Phone: (800) 434-0222	Colorado Senior Health Insurance Assistance Program (SHIP) 4200 W. Conejos Place Ste 200 Denver, CO 80204 Phone: (888) 696-7213	Connecticut CHOICES 25 Sigourney St. 10 th Floor Hartford, CT 06106 Phone: (800) 994-9422 TTY: (800) 342-4524	Delaware ELDERinfo 841 Silverlake Blvd. Dover, DE 19904 Phone: (800) 336-9500
Florida Serving Health Insurance Needs of Elders (SHINE) 5300 Hiatus Rd. Sunrise, FL 33351 Phone: (800) 963-5337 TTY: (954)745-5689	Georgia GeorgiaCares 2 Peachtree St, NW, Ste 9-398 Atlanta, GA 30303 Phone: (800) 669-8387 TTY: (404) 657-1929	Hawaii Sage PLUS 250 South Hotel St, Ste 406 Honolulu, HI 96813 Phone: (888) 875-9229	Idaho Senior Health Insurance Benefits Advisors (SHIBA) 700 West State St., 3rd Floor Boise, ID 83720 Phone: (800) 247-4422
Illinois Senior Health Insurance Program (SHIP) 320 W Washington St Springfield, IL 62767 Phone: (217) 785-9021 TTY: (217) 524-4872	Indiana State Health Insurance Assistance Program (SHIP) 714 W 53rd St Anderson, IN 46013 Phone: (800) 452-4800	Iowa Senior Health Insurance Information Program (SHIIP) 330 Maple st. Des Moines, IA 50319 Phone: (800) 351-4664 TTY: (800) 735-2942	Kansas Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas New England Bldg Topeka, KS 66603 Phone: (800) 860-5260
Kentucky State Health Insurance Assistance Program (SHIP) 275 E. Main St., 3W-F Frankfort, KY 40621 Phone: (877) 293-7447 TTY: (800) 627-4702	Louisiana Senior Health Insurance Information Program (SHIIP) PO Box 94214 Baton Rouge, LA 70804 Phone: (800) 259-5301	Maine Maine State Health Insurance Assistance Program (SHIP) 32 Blossom Lane Augusta, ME 04333 Phone: (877) 353-3771	Maryland Senior Health Insurance Assistance Program (SHIP) 301 West Preston St., Room 1007 Baltimore, MD 21201 Phone: (410) 396-2273 TTY: (410) 767-1083

<p>Massachusetts Serving Health Information Needs of Elders (SHINE) 1 Ashburton Place, 5th Floor Boston, MA 02108 Phone: (617) 727-7750 TTY: (800) 872-0166</p>	<p>Michigan MMAP, Inc. 6105 W St. Joseph, Ste 204 Lansing, MI 48917 Phone: (800) 803-7174</p>	<p>Minnesota Minnesota State Health Insurance Assistance Program/Senior LinkAge Line PO Box 64976 Saint Paul, MN 55164 Phone: (800) 657-3739</p>	<p>Mississippi MS Insurance Counseling and Assistance Program (MICAP) 750 N. State St Jackson, MS 39202 Phone: (601) 359-4342</p>
<p>Missouri CLAIM 200 N Keene St Columbia, MO 65201 Phone: (800) 390-3330 TTY: TDD/TTY available upon request</p>	<p>Montana Montana State Health Insurance Assistance Program (SHIP) 2030 11th Ave Helena, MT 59604 Phone: (800) 551-3191 TTY: (800) 253-4091</p>	<p>Nebraska Nebraska Senior Health Insurance Information Program (SHIIP) 941 O St Ste 400 Lincoln, NE 68508 Phone: (800) 234-7119</p>	<p>Nevada State Health Insurance Advisory Program (SHIP) 1840 E Sahara Ave 110 Las Vegas, NV 89104 Phone: (800) 307-4444</p>
<p>New Hampshire NH SHIP - ServiceLink Resource Center 67 Water St., Ste 105 Laconia, NH 03246 Phone: (866) 634-9412</p>	<p>New Jersey State Health Insurance Assistance Program (SHIP) 240 W State St. Trenton, NJ 08625 Phone: (800) 792-8820</p>	<p>New Mexico Benefits Counseling Program 2550 Cerrillos Rd Santa Fe, NM 87505 Phone: (800) 432-2080</p>	<p>New York Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza New York City, NY 12223 Phone: (800) 701-0501</p>
<p>North Carolina Seniors' Health Insurance Information Program (SHIIP) 11 South Boylan Ave Raleigh, NC 27603 Phone: (800) 443-9354 TTY: (919) 715-0319</p>	<p>North Dakota Senior Health Insurance Counseling (SHIC) State Capitol, 600 East Blvd., 5th Floor Bismarck, ND 58505 Phone: (888) 575-6611</p>	<p>Ohio Ohio Senior Health Insurance Information Program (OSHIIP) 50 West Town St 3rd Floor Columbus, OH 43215 Phone: (800) 686-1578 TTY: (614) 644-3745</p>	<p>Oklahoma Senior Health Insurance Counseling Program (SHIP) 2401 NW 23rd St, Ste 28 Oklahoma City, OK 73152 Phone: (800) 522-0071</p>
<p>Oregon Senior Health Insurance Benefits Assistance (SHIBA) 3410 Cherry Ave Salem, OR 97303 Phone: (800) 722-4134</p>	<p>Pennsylvania APPRISE 555 Walnut St, 5th Floor Harrisburg, PA 17101 Phone: (800) 783-7067</p>	<p>Rhode Island Senior Health Insurance Program (SHIP) Hazard Bldg #74 West Rd Cranston, RI 02920 Phone: (401) 462-4444 TTY: (401) 462-0740</p>	<p>South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais St. Ste 200 Columbia, SC 29201 Phone: (800) 868-9095</p>

<p>South Dakota Senior Health Information & Insurance Education (SHIINE) 700 Governors Dr Pierre, SD 57501 Phone: (866) 854-5465 TTY: (605) 333-3314</p>	<p>Tennessee TN SHIP 500 Deaderick St Ste 825 Nashville, TN 37243 Phone: (877) 801-0044 TTY: (615) 532-3893</p>	<p>Texas Health Information Counseling and Advocacy Program (HICAP) 701 West 51st St Austin, TX 78751 Phone: (800) 252-9240</p>	<p>Utah Senior Health Insurance Information Program (SHIP) 120 North 200 West, Ste 325 Salt Lake City, UT 84103 Phone: (800) 541-7735</p>
<p>Vermont State Health Insurance Assistance Program (SHIP) 481 Summer St Ste 101 St. Johnsbury, VT 05819 Phone: (800) 642-5119</p>	<p>Virginia Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forrest Ave Ste 100 Richmond, VA 23229 Phone: (800) 552-3402</p>	<p>Washington Statewide Health Insurance Benefits Advisors (SHIBA) Helpline PO Box 40256 Olympia, WA 98504 Phone: (800) 562-6900 TTY: (360) 586-0241</p>	<p>Washington D.C. Health Insurance Counseling Project (HICP) 2136 Pennsylvania Ave North West Washington, DC 20052 Phone: (202) 739-0668 TTY: (202) 973-1079</p>
<p>West Virginia West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd E Charleston, WV 25305 Phone: (877) 987-4463</p>	<p>Wisconsin Wisconsin SHIP (SHIP) One West Wilson St. Madison, WI 53703 Phone: (800) 242-1060</p>	<p>Wyoming Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams Riverton, WY 82501 Phone: (800) 856-4398</p>	

Appendix B - Quality Improvement Organizations

<p>Alabama Alabama Quality Assurance Foundation 2 Perimeter Park South Ste 200 West Birmingham, AL 35243 Phone: (800) 760-3540</p>	<p>Alaska Mountain-Pacific Quality Health 4241 B St, Ste 303 Anchorage, AK 99503 Phone: (877) 561-3202</p>	<p>Arizona Health Services Advisory Group, Inc. 1600 E. Northern Ave, Ste. 100 Phoenix, AZ 85020 Phone: (800) 359-9909</p>	<p>Arkansas Arkansas Foundation for Medical Care 2201 Brooken Hill Dr Fort Smith, AR 72908 Phone: (800) 272-5528</p>
--	--	--	--

<p>California Health Services Advisory Group 5201 W Kennedy Blvd Ste 900 Tampa, CA 33609 Phone: (800) 841-1602 TTY: (800) 881-5980</p>	<p>Colorado Colorado Foundation for Medical Care 23 Inverness Way East Ste 100 Englewood, CO 80112 Phone: (800) 950-8250 TTY: (303) 695-3350</p>	<p>Connecticut Qualidigm 1111 Cromwell Ave, Ste 201 Rocky Hill, CT 06067 Phone: (800) 553-7590</p>	<p>Delaware Quality Insights of Delaware Baynard Bldg, Ste 100 3411 Silverside Rd Wilmington, DE 19810 Phone: (866) 475-9669</p>
<p>Florida Florida Medical Quality Assurance 5201 W Kennedy Blvd Ste 900 Tampa, FL 33609 Phone: (800) 844-0795</p>	<p>Georgia Georgia Medical Care Foundation 1455 Lincoln Parkway, Ste 800 Atlanta, GA 30346 Phone: (800) 982-0411</p>	<p>Hawaii Mountain-Pacific Quality Health Foundation 1360 S. Beretania St, Ste 501 Honolulu, HI 96814 Phone: (800) 524-6550</p>	<p>Idaho Mountain-Pacific Quality Health 720 Park Blvd, Ste 120 Boise, ID 83712 Phone: (800) 488-1118</p>
<p>Illinois Illinois Foundation for Quality Health Care 711 Jorie Blvd Ste 301 Oakbrook, IL 60523 Phone: (800) 386-6431</p>	<p>Indiana Health Care Excel, Inc. 2629 Waterfront Parkway East Dr, Ste 200 Indianapolis, IN 46214 Phone: (317) 347-4500</p>	<p>Iowa Iowa Foundation For Medical Care 1776 West Lakes Parkway West Des Moines, IO 50266 Phone: (800) 383-2856</p>	<p>Kansas Kansas Foundation for Medical Care 2947 S.W. Wanamaker Dr Topeka, KS 66614 Phone: (800) 432-0770</p>
<p>Kentucky Health Care Excel, Inc. 9300 Shelbyville Rd., Ste 600 Louisville, KY 40222 Phone: (800) 288-1499</p>	<p>Louisiana Louisiana Health Care Review 8591 United Plaza Blvd, Ste 270 Baton Rouge, LA 70809 Phone: (800) 433-4958</p>	<p>Maine Northeast Health Care Quality Foundation 15 Old Rollinsford Rd, Ste 302 Dover, ME 03820 Phone: (800) 772-0151</p>	<p>Maryland Delmarva Foundation for Medical Care, Inc. 9240 Centreville Rd Easton, MD 21601 Phone: (800) 492-5811</p>
<p>Massachusetts MassPRO 245 Winter St Waltham, MA 02451 Phone: (800) 252-5533</p>	<p>Michigan Michigan Peer Review Organization 22670 Haggerty Rd, Ste 100 Farmington Hills, MI 48335 Phone: (800) 365-5899</p>	<p>Minnesota Stratis Health 2901 Metro Dr, Ste 400 Bloomington, MN 55425 Phone: (800) 444-3423</p>	<p>Mississippi Information and Quality Healthcare 385 B Highland Colony Parkway, Ste 504 Ridgeland, MS 39157 Phone: (800) 844-0600 TTY: (800) 627-3529</p>

<p>Missouri Primaris 200 North Keene St Columbia, MO 65201 Phone: (800) 735-6776</p>	<p>Montana Mountain-Pacific Quality Health Foundation 3404 Cooney Dr Helena, MT 59602 Phone: (800) 497-8232 TTY: (800) 735-2966</p>	<p>Nebraska Cimro of Nebraska 1230 O St, Ste 120 Lincoln, NE 68508 Phone: (800) 458-4262 TTY: (800) 325-0778</p>	<p>Nevada HealthInsight 6830 W. Oquendo Rd, Ste 102 Las Vegas, NV 89118 Phone: (800) 247-3004</p>
<p>New Hampshire Northeast Health Care Quality Foundation 15 Old Rollinsford Rd, Ste 302 Dover, NH 03820 Phone: (800) 772-0151</p>	<p>New Jersey Health Care Quality Strategies 557 Cranbury Rd, Ste 21 East Brunswick, NJ 07960 Phone: (800) 624-4557 TTY: (800) 752-8420</p>	<p>New Mexico New Mexico Medical Review Association 5801 Osuna Rd NW Ste 200 Albuquerque, NM 87109 Phone: (800) 663-6351</p>	<p>New York Island Peer Review Organization - IPRO 1979 Marcus Ave Lake Success, NY 11042 Phone: (800) 331-7767 TTY: (516) 326-6182</p>
<p>North Carolina Medical Review of North Carolina 100 Regency Forest Dr Ste 200 Cary, NC 27518 Phone: (800) 682-2650 TTY: (800) 735-2962</p>	<p>North Dakota North Dakota Health Care Review, Inc. 800 31st Ave, SW Minot, ND 58701 Phone: (888) 472-2902</p>	<p>Ohio Ohio KePRO, Inc. Rock Run Center, 5700 Lombardo Center Dr, Ste 100 Seven Hills, OH 44131 Phone: (800) 589-7337 TTY: (877) 486-2048</p>	<p>Oklahoma Oklahoma Foundation for Medical Quality, Inc. 14000 Quail Springs Pkwy, Ste 400 Oklahoma City, OK 73134 Phone: (405) 840-2891</p>
<p>Oregon Acumentra Health 2020 SW Fourth Ave, Ste 520 Portland, OR 97201 Phone: (503) 279-0100</p>	<p>Pennsylvania Quality Insights of Pennsylvania 2601 Market Place St. Ste 320 Harrisburg, PA 17110 Phone: (877) 346-6180</p>	<p>Rhode Island Rhode Island Quality Partners, Inc. 235 Promenade St. Ste 500, Box 18 Providence, RI 02908 Phone: (800) 662-5028</p>	<p>South Carolina Carolina Center for Medical Excellence 246 Stoneridge Dr Ste 200 Columbia, SC 29210 Phone: (800) 922-3089 TTY: (800) 735-8583</p>
<p>South Dakota South Dakota Foundation for Medical Care, Inc. 2600 West 49th St, Ste 300 Sioux Falls, SD 57117 Phone: (800) 658-2285</p>	<p>Tennessee Foundation for Medical Care, Inc. of the Mid South 3175 Lenox Park Blvd, Ste 309 Memphis, TN 38115 Phone: (800) 489-4633</p>	<p>Texas TMF Health Quality Institute Bridgepoint I, Ste 300 5918 West Courtyard Dr Austin, TX 78730 Phone: (866) 439-5863</p>	<p>Utah HealthInsight 348 E 4500 South, Ste 300 Salt Lake City, UT 84107 Phone: (801) 892-0155</p>

<p>Vermont Northeast Health Care Quality Foundation 15 Old Rollinsford Rd, Ste 302 Dover, VT 03820 Phone: (800) 772-0151</p>	<p>Virginia Virginia Health Quality Center 9830 Mayland Dr, Ste J Richmond, VA 23233 Phone: (800) 545-3814</p>	<p>Washington Mountain-Pacific Quality Health 10700 Meridian N., Ste 100 Seattle, WA 98133 Phone: (800) 949-7536</p>	<p>Washington D.C. Delmarva Foundation for Medical Care, Inc. 2175 K St, NW Ste 250 Washington, DC 20037 Phone: (800) 937-3362</p>
<p>West Virginia West Virginia Medical Institute, Inc. 3001 Chesterfield Place Charleston, WV 25304 Phone: (800) 642-8686</p>	<p>Wisconsin MetaStar, Inc. 2909 Landmark Place Madison, WI 53713 Phone: (800) 362-2320</p>	<p>Wyoming Mountain-Pacific Quality Health Foundation PO Box 2242 Glenrock, WY 82637 Phone: (877) 810-6248</p>	

Appendix C - State Medicaid Agencies

<p>Alabama Medicaid Agency of Alabama 501 Dexter Ave Montgomery, AL 36103 Phone: (334) 242-5000 TTY: (800) 362-1504</p>	<p>Alaska Alaska Dept of Health and Social Services 4501 Business Park Blvd #24 Anchorage, AK 99503 Phone: (800) 780-9972 TTY: (907) 586-4265</p>	<p>Arizona Health Care Cost Containment of AZ 801 E. Jefferson Phoenix, AZ 85034 Phone: (800) 654-8713</p>	<p>Arkansas Dept of Human Services of Arkansas 700 Main St. Little Rock, AR 72201 Phone: (501) 682-1001</p>
<p>California California Dept of Health Services 1501 Capital Ave., Ste 71-463 Sacramento, CA 95889 Phone: (916) 445-4171</p>	<p>Colorado Dept of Health Care Policy and Financing of Colorado 4300 Cherry Creek Dr. S Denver, CO 80246 Phone: (303) 692-2011 TTY: (800) 659-2556</p>	<p>Connecticut Dept of Social Services of Connecticut 25 Sigourney St Hartford, CT 06106 Phone: (800) 842-1508</p>	<p>Delaware Delaware Health and Social Services 1901 N. DuPont Highway, PO Box 906, Lewis Bldg. New Castle, DE 19720 Phone: (302) 255-9500</p>

<p>Florida Agency for Health Care Administration of Florida 2727 Mahan Dr, Mail Stop 26 Tallahassee, FL 32308 Phone: (888) 419-3456</p>	<p>Georgia Georgia Dept of Community Health 2 Peachtree St, NW Atlanta, GA 30303 Phone: (404) 656-4044</p>	<p>Hawaii Dept of Human Services of Hawaii 13 Kekaulike St Honolulu, HI 96720 Phone: (808) 933-0331 TTY: (808) 692-7182</p>	<p>Idaho Idaho Dept of Health and Welfare 1720 W. Gate Dr. Ste A Boise, ID 83704 Phone: (800) 926-2588 TTY: (208) 332-7205</p>
<p>Illinois Illinois Dept of Healthcare and Family Services 201 South Grand Ave, East Springfield, IL 62763 Phone: (800) 226-0768</p>	<p>Indiana Family and Social Services Administration of Indiana 402 W. Washington St Indianapolis, IN 46207 Phone: (800) 545-7763</p>	<p>Iowa Dept of Human Services of Iowa 1900 Carpenter St. Des Moines, IA 50314 Phone: (515) 286-3555</p>	<p>Kansas Dept of Social and Rehabilitation Services of Kansas PO Box 3571 Topeka, KS 66601 Phone: (800) 966-7021</p>
<p>Kentucky Cabinet for Health Services of Kentucky 275 East Main St Frankfurt, KY 40601 Phone: (800) 635-2570</p>	<p>Louisiana Louisiana Dept of Health and Hospital PO Box 629 Baton Rouge, LA 70821 Phone: (225) 342-9500 TTY: (225) 216-7387</p>	<p>Maine Maine Dept of Health and Human Services 442 Civic Center Dr Augusta, ME 04333 Phone: (866) 796-2463 TTY: (800) 644-4331</p>	<p>Maryland Dept of Health and Mental Hygiene 201 West Preston St Baltimore, MD 21201 Phone: (410) 767-5800 TTY: (800) 735-2258</p>
<p>Massachusetts Office of Health and Human Services of Massachusetts One Ashburton Place, Room 1109 Boston, MA 02108 Phone: (617) 573 1770</p>	<p>Michigan Michigan Dept Community Health Capital View Bldg 201 Townsend St Lansing, MI 48913 Phone: (517) 373-3740 TTY: (800) 649-3777</p>	<p>Minnesota Dept of Human Services of Minnesota 444 Lafayette Rd North St. Paul, MN 55155 Phone: (651) 431-2000 TTY: (651) 296-5705</p>	<p>Mississippi Office of the Governor of Mississippi 550 High St Walter Sillens Bldg Ste 1000 Jackson, MS 39201 Phone: (601) 359-6050 TTY: (601) 359-6048</p>
<p>Missouri Dept of Social Services of Missouri 525 Jewels St. Rm.127 St Joseph, MO 64501 Phone: (601) 359-6050</p>	<p>Montana MT Dept of Public Health & Human Services- Child & Adult Health Resources 111 North Sanders, NW, Helena, MT 59620 Phone: (800) 362-8312 TTY: (406) 444-2590</p>	<p>Nebraska Nebraska Dept of Health and Human Services System 301 Cenntenial Mall South Bld D. Lincoln, NE 68509 Phone: (800) 430-3244 TTY: (402) 471-9570</p>	<p>Nevada Nevada Dept of Human Resources, Aging Division 3416 Goni Rd Ste 132 Carson City, NV 89706 Phone: (775) 687-4210</p>

<p>New Hampshire New Hampshire Dept of Health and Human Services 129 Pleasant St Concord, NH 03301 Phone: 800) 852-3345 x4344</p>	<p>New Jersey Dept of Human Services of New Jersey Quakerbridge Plaza, Bldg 7, PO Box 712 Trenton, NJ 08619 Phone: (800) 356-1561</p>	<p>New Mexico Dept of Human Services of New Mexico 2009 S. Pacheco, Pollon Plaza Sante Fe, NM 87504 Phone: (888) 997-2583 TTY: (505) 827-3184</p>	<p>New York New York State Dept of Health Officer of the Commissioner, Empire State Plaza, Corning Tower Bldg, 14th Floor Albany, NY 12237 Phone: (800) 541-2831</p>
<p>North Carolina North Carolina Dept of Health and Human Services 2501 Mail Service Center Raleigh, NC 27699 Phone: (919) 855-4100 TTY: (877) 733-4851</p>	<p>North Dakota Dept of Human Services of North Dakota - Medical Services 600 E. Blvd Ave Dept. 325 Bismarck, ND 58505 Phone: (701) 328-3231</p>	<p>Ohio Dept of Job and Family Services of Ohio - Ohio Health Plans 30 E Broad St, 32nd Floor Columbus, OH 43215 Phone: (800) 686-1516</p>	<p>Oklahoma Health Care Authority of Oklahoma 4545 N. Lincoln Blvd, Ste 124 Oklahoma City, OK 73105 Phone: (800) 522-7300</p>
<p>Oregon Oregon Dept of Human Services 500 Summer St, NE Salem, OR 97301 Phone: (800) 527-5772 TTY: (503) 947-5330</p>	<p>Pennsylvania Dept of Public Welfare of Pennsylvania 243 N 7th St. P.O Box 5959 Harrisburg, PA 17105 Phone: (800) 692-7462 TTY: (717) 705-7103</p>	<p>Rhode Island Dept of Human Services of Rhode Island Louis Pasteur Bldg, 600 New London Ave Cranston, RI 02921 Phone: (800) 984-8989 TTY: (401) 462-3363</p>	<p>South Carolina South Carolina Dept of Health and Human Services PO Box 8206 Columbia, SC 29202 Phone: (888) 549-0820</p>
<p>South Dakota Dept of Social Services of South Dakota 700 Governors Dr, Richard F Kneip Bldg Pierre, SD 57501 Phone: (800) 452-7691</p>	<p>Tennessee Bureau of TennCare 310 Great Circle Rd. Nashville, TN 37243 Phone: (866) 311-4287</p>	<p>Texas Health and Human Services Commission of Texas 4900 N. Lamar Blvd, 4th Floor Austin, TX 78751 Phone: (877) 541-7905 TTY: (512) 407-3250</p>	<p>Utah Utah Dept of Health 288 North 1460 West/PO Box 141012 Salt Lake City, UT 84114 Phone: (800) 662-9651</p>
<p>Vermont Agency of Human Services of Vermont 103 South Main St Waterbury, VT 05671 Phone: (800) 250-8427</p>	<p>Virginia Dept of Medical Assistance Services 600 E Broad St, Ste 1300 Richmond, VA 23219 Phone: (804) 786-7933</p>	<p>Washington Dept of Social and Health Services of Washington PO Box 45130 Olympia, WA 98504 Phone: (800) 562-3022</p>	<p>Washington D.C. DC Healthy Family 1820 Jefferson Place, NW Washington, DC 20036 Phone: (888) 557-1116 TTY: (202) 724-8964</p>

<p>West Virginia West Virginia Dept of Health & Human Resources State Capitol Complex, Bldg 3 Room 206 Charleston, WV 25305 Phone: (800) 642-8589 TTY: (304) 558-1130</p>	<p>Wisconsin Wisconsin Dept of Health and Family Services 1 West Wilson St Madison, WI 53702 Phone: (800) 362-3002 TTY: (608) 267-7371</p>	<p>Wyoming ACS Wyoming Medicaid Equality Card 6101 Yellowstone Rd Cheyenne, WY 82002 Phone: (866) 571-0944 TTY: (307) 777-5648</p>	
---	---	---	--

Appendix D - State Pharmacy Assistance Programs

<p>Colorado Colorado Ryan White Title II ADAP Academic Office 1, Room 7402; 12631 East 17th Ave, MS A089 Aurora, CO 80262 Phone: (303)724-0646</p>	<p>Connecticut Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE) PO Box 5011 Hartford, CT 06102 Phone: (800) 423-5026</p>	<p>Delaware Chronic Renal Disease Program 11-13 North Church Ave Milford, DE 19963 Phone: (302) 424-7180</p>	<p>Delaware (continued) Prescription Assistance Program PO Box 950 New Castle, DE 19720 Phone: (800) 996-9969</p>
<p>Idaho IDAGAP 450 W. State St, 4th Floor Boise, ID 83720 Phone: (208) 334-5943</p>	<p>Illinois Illinois Cares Rx PO BOX 19022 Springfield, IL 62794 Phone: (800)624-2459 TTY: (888) 206-1327</p>	<p>Indiana Hoosier Rx PO Box 6224 Indianapolis, IN 46206 Phone: (866)267-4679</p>	<p>Maine Low Cost Drugs for the Elderly and Disabled Program 442 Civic Center Dr Augusta, ME 04333 Phone: (866) 796-2463 TTY: (800) 325-0778</p>
<p>Maryland Kidney Disease Program of Maryland 201 West Preston St, Rm. SS3 Baltimore, MD 21201 Phone: (410) 767-5000</p>	<p>Maryland (continued) Maryland Senior Prescription Drug Assistance Program 100 Great Meadow Rd, Ste 704 Wethersfield, CT 06109 Phone: (800)551-5995 TTY: (800) 877-5156</p>	<p>Massachusetts Prescription Advantage PO Box 15153 Worcester, MA 01615 Phone: (800)243-4636 TTY: (877) 610-0241</p>	<p>Missouri Missouri Rx Plan PO Box 208 Troy, MO 63379 Phone: (800) 375-1406 TTY: (800) 375-1493</p>

<p align="center">Montana</p> <p>Big Sky Rx Program PO Box 202915 Helena, MT 59620 Phone: (866)369-1233</p> <p>Montana Mental Health Program 205 Haggerty Lane, Ste 170, PO Box 88 Bozeman, MT 59771 Phone: (877)927-6642</p>	<p align="center">Nevada</p> <p>Disability Rx Program 4126 Technology Wy Ste 101 Carson City, NV 89706 Phone: (866) 303-6323</p> <p>Senior Rx Program 4126 Technology Wy Ste 101 Carson City, NV 89706 Phone: (866) 303-6323</p>	<p align="center">New Jersey</p> <p>Prescription Assistance to the Aged and Disabled Program (PAAD) PO Box 715 Trenton, NJ 08625 Phone: (800) 792-9745</p> <p>Senior Gold PO Box 724 Trenton, NJ 08625 Phone: (800) 792-9745</p>	<p align="center">New Jersey (cont)</p> <p>General Public Assistance Program Medicare D Wraparound (GA/Wraparound) P. O. Box 360 Trenton, NJ 08625 Phone: (800) 367-6543</p>
<p align="center">New York</p> <p>Elderly Pharmaceutical Insurance Coverage (EPIC) PO Box 15018 Albany, NY 12212 Phone: (800) 332-3742 TTY: (800) 290-9138</p>	<p align="center">North Carolina</p> <p>NCRx PO Box 10068 Raleigh, NC 27690 Phone: (888) 488-6279</p>	<p align="center">Pennsylvania</p> <p>Pharmaceutical Assistance Contract for the Elderly (PACE) PO Box 8807 Harrisburg, PA 17112 Phone: (800) 225-7223 TTY: (800) 222-9004</p> <p>PACE Needs Enhancement Tier (PACENET) PO Box 8807 Harrisburg, PA 17105 Phone: (800)225-7223 TTY: (800) 222-9004</p>	<p align="center">Pennsylvania (cont)</p> <p>Pennsylvania Chronic Renal Disease Program and General Assistance Program PO Box 8807 Harrisburg, PA 17120 Phone: (800)225-7223 TTY: (800) 222-9004</p> <p>Special Pharmaceutical Benefits Program PO Box 2675, Beechmont Bldg #32 Harrisburg, PA 17105 Phone: (877)356-5355</p>
<p align="center">Rhode Island</p> <p>Rhode Island Prescription Assistance for the Elderly (RIPAE) 74 West Rd Cranston, RI 02920 Phone: (401) 462-3000 TTY: (800) 745-5555</p>	<p align="center">South Carolina</p> <p>Gap Assistance Program for Seniors (GAPS) PO Box 8206 Columbia, SC 29202 Phone: (888)549-0820</p>	<p align="center">Texas</p> <p>Kidney Health Care Program PO Box 149347 Austin, TX 78714 Phone: (800) 222-3986</p> <p>HIV SPAP PO Box 149347 Austin, TX 78714 Phone: (800)255-1090</p>	<p align="center">Vermont</p> <p>V-Pharm 103 S Main St, 3 North Waterbury, VT 05671 Phone: (800) 250-8427</p>

<p>Virginia Virginia Dept of Health HIV SPAP PO Box 1602 Midlothian, VA 23218 Phone: (800)366-7741</p> <p>DMHMRSAS Community SPAP PO Box 1797 Richmond, VA 23218 Phone: (804)786-3921 TTY: (804) 371-8977</p>	<p>Washington Washington State Health Insurance Pharmacy AssiStance Program PO Box 1090 Great Bend, WA 67530 Phone: (800) 877-5187</p>	<p>Wisconsin Chronic Renal Disease PO Box 6410 Madison, WI 53716 Phone: (800)947-9627</p> <p>Cystic Fibrosis Program PO Box 6410 Madison, WI 53716 Phone: (800) 947-9627</p> <p>SeniorCare PO Box 6710 Madison, WI 53716 Phone: (800) 657-2038</p>	<p>Wisconsin (cont) Health Insurance Risk Sharing Plan (HIRSP) 1751 W. Broadway, PO Box 8961 Madison, WI 53708 Phone: (800) 828-4777</p> <p>Hemophilia Home Care PO Box 6410 Madison, WI 53716 Phone: (800) 947-9627</p>
---	--	--	--

Appendix E – Advance Directives Assistance

<p>Alabama Alabama State Board of Medical Examiners 848 Washington Ave P.O. Box 946 Montgomery, AL 36101 Phone: 1-334-242-4116</p>	<p>Alaska Dept of Health & Social Services Division of Public Health 350 Main St, Ste 503 Juneau, AK 99801 Phone: 1-907-465-3092</p>	<p>Arizona Arizona Medical Board 9545 E. Doubletree Ranch Rd Scottsdale, AZ 85258 Phone: 1-480-551-2700</p>	<p>Arkansas Arkansas State Medical Board 2100 Riverfront Dr Little Rock, AR 72202 Phone: 1-501-296-1802</p>
<p>California Attorney General's Office California Dept of Justice P.O. Box 944255 Sacramento, CA 94244 Phone: 1-916-322-3360</p>	<p>Colorado Dept of Regulatory Agencies Board of Medical Examiners 1560 Broadway, Ste 1350 Denver, CO 80202 Phone: 1-303-894-7690</p>	<p>Connecticut Connecticut State Medical Society 190 St. Ronan St New Haven, CT 06511 Phone: 1-203-865-0587</p>	<p>District of Columbia D.C. Board of Medicine 825 N. Capitol St NE Room 2224 Washington, DC 20002 Phone: (202) 671-5000</p>
<p>Delaware Board of Medical Practice Division of Professional Regulation Cannon Bldg, Ste 203 861 Silver Lake Blvd Dover, DE 19904 Phone: 1-302-744-4500</p>	<p>Florida Florida Board of Medicine Medical Quality Assurance 4052 Bald Cypress Way Tallahassee, FL 32399 Phone: 1-850-245-4224</p>	<p>Georgia Composite State Board of Medical Examiners Enforcement Unit Two Peachtree St, NW, 36th Floor Atlanta, GA 30303 Phone: 1-404-657-6487</p>	<p>Hawaii Regulated Industries Complaints Office Dept. of Commerce & Consumer Affairs 235 S. Beretania St, 9th Fl Honolulu, HI 96813 Phone: 1-808-586-2653</p>

<p>Idaho Idaho Board of Medicine 1755 Westgate Dr Boise, ID 83720 Phone: 1-208-327-7000</p>	<p>Illinois Dept of Financial & Professional Regulation Division of Professional Regulation Complaint Intake Unit 100 West Randolph St, Ste 9-300 Chicago, IL 60601 Phone: 1-312-814-6910</p>	<p>Indiana The Indiana State Medical Association 322 Canal Walk Indianapolis, IN 46202 Phone: 1-317-261-2060</p>	<p>Iowa Iowa Board of Medicine 400 SW 8th St, Ste C Des Moines, IA 50309 Phone: 1-515-281-5171</p>
<p>Kansas Kansas State Board of Healing Arts 235 S. Topeka Boulevard Topeka, KS 66603 Phone: 1-785-296-7413</p>	<p>Kentucky Kentucky Board of Medical Licensure 310 Whittington Parkway, Ste 1B Louisville, KY 40222 Phone: 1-502-429-7150</p>	<p>Louisiana Louisiana State Board of Medical Examiners P.O. Box 30250 New Orleans, LA 70130 Attn: Office of Investigations and Enforcement Phone: 1-504-568-6820</p>	<p>Maryland Dept of Health and Mental Hygiene Maryland Board of Physicians 4201 Patterson Avenue Baltimore, MD 21215 Phone: 1-410-764-4777 TTY: 1-800-735-2258</p>
<p>Massachusetts Massachusetts Medical Society 860 Winter St Waltham, MA 02451 Phone: 1-781-893-4610</p>	<p>Michigan Michigan State Medical Society (MSMS) 120 West Saginaw S East Lansing, MI 48823 Phone: 1-517-337-1351</p>	<p>Minnesota Minnesota Attorney General's Office 1400 Bremer Tower 445 Minnesota St St. Paul, MN 55101 Phone: 1-651-296-3353 TTY: 1-800-366-4812</p>	<p>Mississippi Mississippi Dept of Human Services Division of Aging and Adult Services 750 North State St Jackson, MS 39202 Phone: 1-601-359-4929</p>
<p>Missouri Board of Registration for the Healing Arts 3605 Missouri Boulevard P.O. Box 4 Jefferson City, MO 65102 Phone: 1-573-751-0098 TTY: 1-800-735-2966</p>	<p>Montana State of Montana Dept of Labor and Industry Health Care Licensing Bureau 301 South Park Avenue, Room 430 P.O. Box 200513 Helena, MT 59620 Phone: 1-406-841-2333</p>	<p>Nebraska Dept of Health and Human Services Division of Public Health Investigations P.O. Box 95164 Lincoln, NE 68509 Phone: 1-402-471-0175</p>	<p>Nevada Nevada Board of Medical Examiners Complaint Investigation Division P.O. Box 7238 Reno, NV 89510 Phone: 1-775-688-2559</p>
<p>New Jersey New Jersey Office of the Attorney General Division of Consumer Affairs State Board of Medical Examiners 140 East Front St, 2nd Floor P.O. Box 183 Trenton, NJ 08625 Phone: 1-609-826-7100</p>	<p>New Mexico New Mexico Medical Board 2055 So. Pacheco St, Building 400 Santa Fe, NM 87505 Phone: 1-505-473-7220</p>	<p>North Dakota North Dakota State Board of Medical Examiners City Center Plaza 418 Broadway Ave, Ste 12 Bismarck, ND 58501 Phone: 1-701-328-6500</p>	<p>Ohio State Medical Board of Ohio 30 E. BRd St, 3rd Floor Columbus, OH 43215 Phone: 1-614-466-3934</p>

<p>Oklahoma Oklahoma State Board of Medical Licensure and Supervision Investigations Dept P.O. Box 18256 Oklahoma City, OK 73154 Phone: 1-405-848-6841 ext. 134</p>	<p>Pennsylvania Pennsylvania Office of the Attorney General Health Care Section 14th Floor, Strawberry Square Harrisburg, PA 17120 Phone: 1-717-705-6938</p>	<p>Rhode Island Patrick C. Lynch: Dept of the Attorney General 150 South Main St Providence, RI 02903 Phone: 1-401-274-4400</p>	<p>South Carolina South Carolina Board of Medical Examiners P.O. Box 11289 Columbia, SC 29211 Phone: 1-803-896-4500</p>
<p>South Dakota Complaint Committee SD Board of Medical and Osteopathic Examiners 125 S. Main Avenue Sioux Falls, SD 57104 Phone: 1-605-367-7781</p>	<p>Tennessee Tennessee Dept of Health Office of Investigations Heritage Place, Metro Center 227 French Landing, Ste 201 Nashville, TN 37243 Phone: 1-615-741-8485</p>	<p>Texas Texas Medical Board Investigations Dept, MC-263 P.O. Box 2018 Austin, TX 78768 Phone: 1-800-201-9353</p>	<p>Utah Utah Division of Consumer Protection Attention: Complaint Processor Heber M. Wells Building, Second Floor 160 East 300 South, SM Box 146704 Salt Lake City, UT 84114 Phone: 1-801-530-6601</p>
<p>Vermont Vermont Dept of Health Board of Medical Practice 108 Cherry St P.O. Box 70 Burlington, VT 05402 Phone: 1-802-657-4220</p>	<p>Virginia Commonwealth of Virginia Enforcement Division Dept of Health Professions 9960 Maryland Dr, Ste 300 Richmond, VA 23233 Phone: 1-804-367-4691</p>	<p>West Virginia Complaint Committee West Virginia Board of Medicine 101 Dee Dr, Ste 103 Charleston, WV 25311 Phone: 1-304-558-2921</p>	<p>Wisconsin Wisconsin Dept of Regulation and Licensing P.O. Box 8935 Madison, WI 53708 Phone: 1-608-266-7482</p>
<p>Wyoming Wyoming Board of Medicine 320 W. 25th St, Ste 103 Cheyenne, WY 82002 Phone: 1-307-778-7053</p>			

EnvisionRx Plus Gold Member Services

CALL	1-866-250-2005 Calls to this number are free. Member Services, including TTY, is open 24 hours a day, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-866-250-5178
WRITE	EnvisionRx Plus P.O. Box 1298 Twinsburg, OH 44087 customerservice@envisionrxplus.com
WEBSITE	www.envisionrxplus.com

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. You can find the name of your state SHIP in Appendix A.