



A Medicare Approved Prescription Drug Plan

MedicareRx  
Prescription Drug Coverage X

## PLAN S7694 - 2012 SUMMARY OF BENEFITS

### INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in **EnvisionRx Plus Gold** (PDP). Our plan is offered by ENVISION INSURANCE COMPANY/EnvisionRx Plus, a Medicare Prescription Drug Plan that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call **EnvisionRx Plus Gold** (PDP) and ask for the "Evidence of Coverage".

### YOU HAVE CHOICES IN YOUR MEDICARE PRESCRIPTION DRUG COVERAGE

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like **EnvisionRx Plus Gold** (PDP). Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

### HOW CAN I COMPARE MY OPTIONS?

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by **EnvisionRx Plus Gold** (PDP) to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

### WHERE IS ENVISIONRX PLUS GOLD (PDP) AVAILABLE?

The service area for this plan includes Alaska, Arkansas, Florida, Hawaii, Illinois, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Wisconsin, and Wyoming.

You must live in one of these areas to join this plan. If you move out of the state or county where you currently live to a state listed above, you must call Customer Service to update your information. If you don't, you may be disenrolled from **EnvisionRx Plus Gold**. If you move to a state not listed above, please call Customer Service to find out if Envision Insurance Company has a plan in your new state or county.

### WHO IS ELIGIBLE TO JOIN?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area.

If you are enrolled in an MA coordinated care (HMO or PPO) plan or an MA PFFS plan that includes Medicare prescription drugs, you may not enroll in a PDP unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private fee-for-service plan (PFFS) that does not provide Medicare prescription drug coverage, or an MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP.

## **WHERE CAN I GET MY PRESCRIPTIONS?**

**EnvisionRx Plus Gold** (PDP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or visit us at [www.envisionrxplus.com](http://www.envisionrxplus.com). Our customer service number is listed at the end of this introduction.

## **DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?**

**EnvisionRx Plus Gold** (PDP) does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

## **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

**EnvisionRx Plus Gold** (PDP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at [www.envisionrxplus.com](http://www.envisionrxplus.com).

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **WHAT SHOULD I DO IF I HAVE OTHER INSURANCE IN ADDITION TO MEDICARE?**

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join **EnvisionRx Plus Gold** (PDP). Get this information before you decide to enroll in this plan.

## **HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?**

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

\* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see [www.medicare.gov](http://www.medicare.gov) 'Programs for People with Limited Income and Resources' in the publication Medicare You.

\* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or

\* Your State Medicaid Office.

## **WHAT ARE MY PROTECTIONS IN THIS PLAN?**

All Medicare Prescription Drug Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with the Medicare Prescription Drug Plan Program. A plan may continue in

their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Prescription Drug Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of **EnvisionRx Plus Gold** (PDP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

#### **WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?**

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact **EnvisionRx Plus Gold** (PDP) for more details.

#### **WHERE CAN I FIND INFORMATION ON PLAN RATINGS?**

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call **EnvisionRx Plus** for more information about **EnvisionRx Plus Gold** (PDP).

Visit us at [EnvisionRxPlus.com](http://EnvisionRxPlus.com) or, call us:

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Open 24 Hours Eastern

Current members should call toll-free (866)-250-2005. (TTY/TDD 711)

Prospective members should call toll-free (866)-250-2005. (TTY/TDD 711)

Current members should call locally (866)-250-2005. (TTY/TDD 711)

Prospective members should call locally (866)-250-2005. (TTY/TDD 711)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en otros formatos como Braille, letra grande o en otros formatos alternativos.

Este documento puede estar disponible en un idioma que no sea Inglés. Para obtener más información, llame al servicio al cliente al número de teléfono que aparece arriba.

**If you have any questions about this plan's benefits or costs, please contact EnvisionRx Plus for details.**

**SUMMARY OF BENEFITS**

<b>Benefit</b>	<b>Original Medicare</b>	<b><i>EnvisionRx Plus Gold (PDP)</i></b>
Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	<b>Drugs covered under Medicare Part D</b>
		<b>General</b>
		This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.envisionrxplus.com">www.envisionrxplus.com</a> on the web.
		Different out-of-pocket costs may apply for people who
		<ul style="list-style-type: none"> <li>• have limited incomes,</li> </ul>
		<ul style="list-style-type: none"> <li>• live in long term care facilities, or</li> </ul>
		<ul style="list-style-type: none"> <li>• have access to Indian/Tribal/Urban (Indian Health Service) providers.</li> </ul>
		Premiums range from \$54.50 to \$82.50. Please refer to the Premium Table after this section to find out the premium in your area.
		Most people will pay their Part D premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
		The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).
		Total yearly drug costs are the total drug costs paid by both you and a Part D plan.
		The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
		Some drugs have quantity limits.
Your provider must get prior authorization from <b><i>EnvisionRx Plus Gold (PDP)</i></b> for certain drugs.		
You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on <a href="http://Medicare.gov">Medicare.gov</a> .		
If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.		

**SUMMARY OF BENEFITS**

Benefit	Original Medicare	<i>EnvisionRx Plus Gold (PDP)</i>
		If you request a formulary exception for a drug and <i>EnvisionRx Plus Gold (PDP)</i> approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost sharing for that drug.
		<b>IN-NETWORK</b>
		\$0 deductible.
		<b>INITIAL COVERAGE</b>
		You pay the following until total yearly drug costs reach \$2,930:
		<b>RETAIL PHARMACY</b>
		<b>Tier 1: Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• \$2 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$6 copay for a three-month (90-day) supply of drugs in this tier</li> </ul>
		<b>Tier 2: Non-Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• 15% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>• 15% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul>
		<b>Tier 3: Preferred Brand Drugs</b>
		<ul style="list-style-type: none"> <li>• 15% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>• 15% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul>
		<b>Tier 4: Non-Preferred Brand Drugs</b>
		<ul style="list-style-type: none"> <li>• 30% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>• 30% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul>
		<b>Tier 5: Specialty Tier Drugs</b>
		<ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>
		<b>LONG TERM CARE PHARMACY</b>
		<b>Tier 1: Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• \$2 copay for a one-month (31-day) supply of drugs in this tier</li> </ul>
		<b>Tier 2: Non-Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• 15% coinsurance for a one-month (31-day) supply of drugs in this tier</li> </ul>
		<b>Tier 3: Preferred Brand Drugs</b>
		<ul style="list-style-type: none"> <li>• 15% coinsurance for a one-month (31-day) supply of drugs in this tier</li> </ul>
		<b>Tier 4: Non-Preferred Brand Drugs</b>
		<ul style="list-style-type: none"> <li>• 30% coinsurance for a one-month (31-day) supply of drugs in this tier</li> </ul>
		<b>Tier 5: Specialty Tier Drugs</b>
		<ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (31-day) supply of drugs in this tier</li> </ul>
		<b>MAIL ORDER</b>
		<b>Tier 1: Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• \$6 copay for a three-month (90-day) supply of drugs in this tier</li> </ul>
		<b>Tier 2: Non-Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• 15% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul>
		<b>Tier 3: Preferred Brand Drugs</b>
		<ul style="list-style-type: none"> <li>• 15% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul>
		<b>Tier 4: Non-Preferred Brand Drugs</b>
		<ul style="list-style-type: none"> <li>• 30% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul>
		<b>Tier 5: Specialty Tier Drugs</b>
		<ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>
		<b>ADDITIONAL COVERAGE GAP</b>
		The plan covers some formulary generics (10%-64% of formulary generic

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Benefit	Original Medicare	<i>EnvisionRx Plus Gold (PDP)</i>
		drugs) through the coverage gap. You pay the following:
		<b>RETAIL PHARMACY</b>
		<b>Tier 1: Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• \$2 copay for a one-month (30-day) supply of all drugs covered in this tier</li> <li>• \$6 copay for a three-month (90-day) supply of all drugs covered in this tier</li> </ul>
		<b>LONG TERM CARE PHARMACY</b>
		<b>Tier 1: Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• \$2 copay for a one-month (31-day) supply of all drugs covered in this tier</li> </ul>
		<b>Mail Order</b>
		<b>Tier 1: Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• \$6 copay for a three-month (90-day) supply of all drugs covered in this tier</li> </ul>
		After your total yearly drug costs reach \$2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,700.
		<b>CATASTROPHIC COVERAGE</b>
		After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:
		<ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.</li> </ul>
		<b>OUT-OF-NETWORK</b>
		Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from <i>EnvisionRxPlus Gold (PDP)</i> .
		<b>OUT-OF-NETWORK INITIAL COVERAGE</b>
		You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:
		<b>Tier 1: Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• \$2 copay for a one-month (30-day) supply of drugs in this tier</li> </ul>
		<b>Tier 2: Non-Preferred Generic Drugs</b>
		<ul style="list-style-type: none"> <li>• 15% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>
		<b>Tier 3: Preferred Brand Drugs</b>
		<ul style="list-style-type: none"> <li>• 15% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>
		<b>Tier 4: Non-Preferred Brand Drugs</b>
		<ul style="list-style-type: none"> <li>• 30% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>
		<b>Tier 5: Specialty Tier Drugs</b>
		<ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>
		You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
		<b>ADDITIONAL OUT-OF-NETWORK COVERAGE GAP</b>

**SUMMARY OF BENEFITS**

Benefit	Original Medicare	<i>EnvisionRx Plus Gold (PDP)</i>
		You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:
		<p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• \$2 copay for a one-month (30-day) supply of all drugs covered in this tier</li> </ul>
		<p><b>Tier 2: Non-Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>• You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</li> <li>• You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</li> </ul>
		<p><b>Tier 3: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</li> <li>• You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</li> </ul>
		<p><b>Tier 4: Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>• You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</li> <li>• You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</li> </ul>
		<p><b>Tier 5: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>• You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</li> <li>• You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</li> </ul>
		You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
		<b>OUT-OF-NETWORK CATASTROPHIC COVERAGE</b>
		After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:
		<ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> </ul>
		<ul style="list-style-type: none"> <li>• \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.</li> </ul>
		You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

***EnvisionRx Plus Gold***  
**2012 Plan Premiums**

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