*[**Legend for Model EOC:***
Placeholders for Variable are located within < > and highlighted in grey
Instructions are located within [ ] and highlighted in grey
Optional elements are located within { } and highlighted in grey]

2006 PDP Model EOC

EVIDENCE OF COVERAGE:

Your Medicare prescription drug coverage as a Member of <Organization name/Part D Plan>

January 1 – December 31, <insert year>

This booklet gives the details about your Medicare prescription drug coverage. This booklet is an important legal document. Please keep it in a safe place.

<Organization Name/Part D Plan> Customer service:

For help or information, please call Customer service <insert days of week>, <insert hours>. Calls to these numbers are free:

1-xxx-xxx-xxxx

TTY/TDD: 1-xxx-xxx-xxxx

Introduction Welcome <Part D Plan>

Welcome to <Part D Plan>!

We are pleased that you've chosen <Part D Plan>.

<Part D Plan> is a Medicare Prescription Drug Plan

Now that you are enrolled in <Part D Plan>, you are getting your Medicare prescription drug coverage through <name of organization>. <Part D Plan>, a Medicare Prescription Drug Plan, is offered by <organization name>.

This booklet explains how to get your Medicare prescription drug coverage through <Part D Plan>

This booklet, together with your enrollment form, riders, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of <Part D Plan>. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, <insert year>, through December 31, <insert year>.

This booklet gives you the details, including:

- What is covered in <Part D Plan> and what is not covered.
- How to get your prescriptions filled, including some rules you must follow.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave <Part D Plan>, including your choices for continuing Medicare prescription drug coverage.
- If you need to receive this booklet in a different format (such as in [*insert examples of what formats are available, such as Spanish, large print, or audio tapes*]), please call us so we can send you a copy.

Please tell us how we're doing

We want to hear from you about how well we are doing as your Medicare Prescription Drug Plan. You can call or write to us at any time – your comments are always welcome, whether they are positive or negative. From time to time, we conduct surveys that ask our members to tell about their experiences with <Part D Plan>. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

How to contact **<Part D Plan>** *Customer service*

If you have any questions or concerns, please call or write to <Part D Plan> Customer service. We will be happy to help you. Our business hours are <Insert days of week and hours>.

CALL	<Plan phone number>. This number is also on the cover of this booklet for easy reference. Calls to this number are free. [*You may also include reference to 24-hour lines here*]
TTY/TDD	<Plan phone number>. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.
FAX	{*Optional:* <Plan fax number>}
WRITE	[*Insert address* – You may also include e-mail addresses here]
VISIT	{*Optional: <Plan physical address>*}.

How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline

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, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS contracts with and regulates Medicare Prescription Drug Plans (including <Part D Plan>).

Here are ways to get help and information about Medicare from CMS:

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free.

Use a computer to look at www.medicare.gov, the official **government Web site for Medicare information.** This Web site gives you a lot of up-to-date information about Medicare and nursing homes. It includes Medicare publications you can print directly from your computer. It has tools to help you compare Medicare managed care plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

<State-specific name of SHIP / SHIP> – *an organization in your state that provides free Medicare help and information*

[*If your EOC is for a single state, replace all mentions of "SHIP" in heading with the actual name of the SHIP for that state, and adapt other parts of the text as needed to accommodate this substitution.*]

<State-specific name of SHIP> is a state organization paid by the Federal government to give free health insurance information and help to people with Medicare. <State-specific name of SHIP> can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. <State-specific name of SHIP> has information about Medicare Prescription Drug Plans, Medicare managed care plans and Medigap (Medicare supplemental insurance) policies. You can contact <State-specific name of SHIP> at [*Insert name, address, and telephone number for the SHIP*]. You can also find the Web site for <state-specific name of SHIP> at www.medicare.gov.

[*If your EOC is for multiple states, replace the references to "state specific SHIP" in heading with "SHIP," and adapt other parts of the text as needed to accommodate this substitution.*]

"SHIP" stands for State Health Insurance Assistance Program. SHIPs are state organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare managed care plans, and about Medigap (Medicare supplement insurance) policies.

You can contact the SHIP in your state at [*Insert name, address, and telephone number for all applicable SHIPS*]. You can also find the Web site for your local SHIP at www.medicare.gov.

Other organizations

Medicaid agency – a state government agency that handles health care programs for people with low incomes

[*You may adapt this generic discussion of Medicaid to reflect the name and features of the Medicaid program in your state or states.*] Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact [*Insert name, address, and telephone number for all applicable state Medicaid agencies/state departments of health and social services. You may also add your Customer service contact information.]*

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 312-751-4701. You can also visit www.rrb.gov.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

[*Insert this paragraph if the plan has SPAPs in your service area*]
[State Pharmacy Assistance Program

State Pharmacy Assistance Programs (SPAPs) are state-funded programs that provide low-income and medically needy senior citizens and individuals with disabilities financial assistance for prescription drugs. Some SPAPs will help pay for your premiums, deductibles, and co-payments. Please contact a SPAP in your state to determine what benefits are available to you.
[*Insert all SPAPs in the plan's service area, including their contact information.*]]

SECTION 1 <Part D Plan> Basics

What is <Part D Plan>?

<Part D Plan>is offered by <organization name>, and is a Medicare Prescription Drug Plan. Now that you are enrolled in <Part D Plan>, you are getting your Medicare prescription drug coverage through <name of organization>. This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare prescription drug coverage

Medicare prescription drug coverage is insurance where we help pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a <Part D Plan> network pharmacy, and other plan rules are followed. We do not pay for drugs that are covered by Medicare Part B. As a member, all you have to do is continue to pay your monthly premium and pay applicable <deductibles>, co-pays, and co-insurances. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. If you have limited income and resources, you may get extra help from Medicare to pay your premium, <deductible>, co-payments, and co-insurances so that you get your prescription drugs for little or no cost. Please see Section 2 or call Customer Service to learn more.

Help us keep your membership record up-to-date

[*In the heading and in this paragraph, substitute the name you use for this file if different from "membership record"*] <Name of organization> has a file of information about you as a plan member. Pharmacists use this membership record to know what drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific <Part D Plan>coverage and other information. Section 9 tells you how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Customer Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident.

What is the geographic service area for **<Part D Plan>**

The states in our service area are listed below. {*Optional:* You may include a map of the area (in addition to listing the service area), and modify the prior sentence to refer readers to the map.} [*Insert plan service area listing.*]

Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of <Part D Plan>, you have a <Part D Plan> membership card. Here is a sample card to show what it looks like:

[*Insert Membership Card Diagram here – front and back. Mark it as a sample card (for example, by superimposing the word "sample" across the card)*]

During the time you are a plan member and using plan services, you *must* use your plan membership card instead of your red, white, and blue Medicare card at network pharmacies. Please carry your <Part D Plan> membership card with you at all times. You will need to show this card in order to get your prescription drugs paid for. If your membership card is ever damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Using plan pharmacies to get your prescription drugs covered by <Part D Plan>

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

- **What is a "network pharmacy"?** A network pharmacy is a pharmacy where you can receive your prescription drug benefits. We call them "network pharmacies" because they contract with <Part D Plan>. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies.
- [*Insert the following sentence if the plan has preferred pharmacies:* We have a list of **preferred pharmacies**. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. A **non-preferred pharmacy** is still a network pharmacy, but you may have to pay more for your prescriptions. Please refer to your pharmacy directory or call Customer Service to locate a preferred pharmacy.]
- **What are "covered drugs"?** "Covered drugs" is the general term we use in this booklet to mean all of the outpatient prescription drugs that are covered by <Part D Plan>. Covered drugs are listed in the Benefits Chart in Section 4.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your <Part D Plan> Member ID card at one of our network pharmacies. If you do not have your ID card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of <Part D Plan> network pharmacies.

[*Insert the name of your pharmacy directory, if different from "Pharmacy Directory." It is optional to add more detail to this paragraph that describes what information is available in your Pharmacy Directory, on your Web site, or from Customer Service.*]
Every year as long as you are a member of <Part D Plan>, we will send you a Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find a network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Customer service. They can also give you the most up-to-date information about changes in <Part D Plan>'s pharmacy network. In addition, you can find this information on our Web site at <Insert Web site>.

What if a pharmacy is no longer a "network pharmacy"?

Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another <Part D Plan> network pharmacy. Please refer to your pharmacy directory or call Customer Service to find another network pharmacy in your area.

How do I fill a prescription through <Part D Plan>'s mail order pharmacy service?

[If your mail order service includes drugs other than "maintenance drugs," substitute the following sentence for the rest of the paragraph that follows, adapting as needed for accuracy: You can use the <Part D Plan> mail order service to fill prescriptions for any drug that is marked as a mail-order drug on the formulary list.*]*

You can use the mail order service to fill prescriptions for what we call <"mail order drugs" / "maintenance drugs."> . These are drugs that you take on a regular basis, for a chronic or long-term medical condition. The formulary list tells you which drugs we consider to be <mail order / maintenance drugs>. [*Add the following if applicable, adapting as needed:* These are the only drugs available through our mail order service.]

[Include the following, if applicable, adapting as needed for accuracy: When you order prescription drugs by mail, you must order at least a <60>-day supply, and no more than a <90>-day supply of the drug. For some <mail order / maintenance drugs>, a *refill* prescription is covered only if you get it through our mail order service (the formulary list tells you which ones). *]*

You are not required to use mail order prescription drug services to obtain an extended supply of maintenance medications. Some retail pharmacies may agree to accept the mail order co-payment for an extended supply of medications, which may result in no out-of-pocket payment difference to you. Please call our Customer Service Department at <phone number and TTY/TDD number> for more information.

Generally, it takes us <xx> days to process your order and ship it to you. However, sometimes your mail order may be delayed. [*Insert Plan's process for enrollees to obtain a prescription if the mail order is delayed.*]

Filling prescriptions outside the network

What if I need a prescription because of a medical emergency?

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

Getting coverage when you travel or are away from the plan's service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our mail order pharmacy service.

If you are traveling within the US and become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. In this situation, you will have to pay the full cost (rather than paying just your

co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

Prior to filling your prescription at an out of network pharmacy, call our Customer Service to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, our Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

Other times you can get your prescription covered if you go to an out-of-network pharmacy

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24 hour service.
- If you are trying to fill a prescription covered drug that is not regularly stocked at an accessible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

Before you fill your prescription in either of these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out of network pharmacy for the reasons listed above, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described next.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. When you return home, simply submit your claim and your receipt to the following address: <Plan address>. Upon receipt, we will make an initial coverage determination on the claim. Please see Section 7 or call Customer Service for more information on initial coverage determinations.

Specialty Pharmacies

Home infusion pharmacies

<Part D Plan> will cover home infusion therapy if:

- Your prescription drug is on <Part D Plan>'s formulary,
- You have followed all required utilization management rules and <Part D Plan> has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your home infusion services from a <Part D Plan> network pharmacy.

[*Insert any additional information on home infusion pharmacy services in the network.*]
Please refer to your pharmacy directory to find a home infusion pharmacy in your area. For more information, please contact Customer Service.

Long-term care pharmacies

Residents of a long-term care facility must access their prescription drugs through their long-term care pharmacy. In some cases the long-term care pharmacy will not contract with some Medicare Prescription Drug Plans. Please refer to your pharmacy directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Customer Service.
[*Insert any additional information on Long-term Care pharmacy services in their network.*]

[*Insert the following section if the network contains I/T/U Pharmacies.*]
[Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through <Part D Plan>'s pharmacy network.

[*Insert any additional information on I/T/U pharmacy services in their network.*]
Please refer to your pharmacy directory to find an I/T/U pharmacy in your area. For more information, please contact Customer Service.**]**

Some vaccines and drugs may be administered in your doctor's office

We cover all vaccines that are medically necessary but are not covered by Medicare Part B, and some covered drugs that are administered in your doctor's office.

Section 2: Extra Help with Drug Plan Costs for People with Limited Income and Resources

What Is Extra Help?

Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug costs. If you qualify, you will get help paying for your drug plan's monthly premium, yearly deductible, and prescription co-payments.

Do I Qualify for Extra Help?

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below $14,355 (or $19,245 if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,500 (or $23,000 if you are married). The amount of extra help you get will depend on your income and resources.

Note: Amounts shown above are for 2005. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call Customer Service to find out what the income limits are.

Some people automatically qualify for extra help and do not have to apply for it. If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid program that currently pays for your prescriptions?
- Do you get Supplemental Security Income?
- Do you get help from your state Medicaid program paying your Medicare premiums (belong to a Medicare Savings Program)?

What Do I Do Next?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will receive a letter in the mail letting you know if you qualify or not and what you need to do next.

Even if you do not qualify for extra help, <Part D Plan> pays about half of your prescription drug costs, even without any extra help.

How Do I Get More Information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about <Part D Plan>, please contact Customer Service at <toll-free number>, <days and hours of operation>. TTY/TDD users should call <toll-free TTY/TDD number>. Or, visit <Web address>.

SECTION 3 Monthly Premium

Please Note: *If you are receiving extra help with paying for your drug coverage, the premium amount that you pay as a member of <Part D Plan> is listed in your Evidence of Coverage Rider. Or, if you are a member of a State Pharmaceutical Assistance Program (SPAP), you may receive help paying your premiums. Please contact your SPAP to determine what benefits are available to you.*

Paying the plan premium for your coverage as a member of **<Part D Plan>**

How much is your monthly plan premium and how do you pay it?

In <Part D Plan>, you must pay a $___ premium each month.

There are two ways to pay your monthly plan premium.

Option one: Pay your monthly plan premium directly to <Part D Plan>.
[*Insert plan specifics on how they can pay by check, including an address, whether they can drop off a check in person, and by what day the check must be received (e.g., the 5th of each month). If the plan uses coupon books, explain when they will receive it and to call Customer Service for a new one if they run out or lose it. In addition, include information if you charge for nonsufficient fund (NSF) checks.*]

If you prefer, you can also have your monthly premium automatically withdrawn from your bank account. [*Insert plan specific information on how this can be set up.*]

Option two: Have your monthly plan premium directly deducted from your monthly Social Security check. Contact your local Social Security office for more information on how to pay your premium this way.

[*If members should call some place other than Customer Service, replace the reference to Customer Service with the name of the applicable department or place, and include the phone number and TTY/TDD number, listing hours of operation for both numbers.*] If you have any questions about your plan premiums or the different ways to pay them, please call Customer Service at <Plan Name phone number, TTY/TDD number>.

What Happens If You Don't Pay Your Plan Premiums, Or Don't Pay Them On Time?

[*Delete this subsection if the plan does not take action by disenrolling members who fail to pay their premiums.*]

If your plan premiums are past due, we will tell you in writing when a [xx]-day grace period begins. Failure to pay your past-due plan premiums within the [xx]-day grace period will result in your disenrollment. Disenrollment ends your membership in <Part D Plan>. If you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Election Period, unless you qualify for a Special Enrollment Period. If you do not qualify for a Special Enrollment Period or have another source of credible prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage. [*Insert if applicable to the plan:* If you should decide to re-enroll in <Part D Plan> during the next Annual Coordinated Election Period, or to enroll in another plan offered by [organization name], you will have to pay any past-due plan premiums that you still owe from your previous enrollment in <Part D Plan>.]

Please see Section 9 or call Customer Service to find out more about enrollment periods.

Can Your Plan Premiums Change During the Year?

Generally, no. In limited circumstances, your plan premium may change owing to a change in family circumstances such as if you get married. The Social Security Administration or State Medical Assistance Office will tell you if there is a change. We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1, <year>.

Do I Have To Continue To Pay My Part A Or Part B Premiums?

To be a member of <Part D Plan>, you must either be entitled to Medicare Part A or enrolled in Medicare Part B and live in our service area. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a member of this plan.

Some members who belong to a Medicare Savings Program (QMB, SMB, QI) may be eligible to receive extra help in paying for the cost of their prescriptions drugs. Please see Section 2 or call Customer Service for more information.

What is the late enrollment penalty?

You will have to pay a late enrollment penalty in addition to your monthly plan premium if you do not enroll in a Medicare Prescription Drug Plan during your initial enrollment period and you do not have *creditable* coverage for a continuous period of at least 63 days after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the late enrollment penalty will increase every year. This applies to low-income subsidy eligible beneficiaries as well.

Section 4 Coverage for Prescription Drugs

This section describes the prescription drug coverage you receive as a member of <Part D Plan>. <Part D Plan> has a formulary, or list of covered drugs. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a <Part D Plan> network pharmacy, and other plan rules are followed. Later we will explain how much you will pay when you fill a prescription for a covered drug.

What Drugs Are Covered By Medicare Prescription Drug Plans?

Medicare Prescription Drug Plans can cover any drug as long as it is available by prescription, is approved by the Food and Drug Administration (FDA), and is sold in the United States. Over the counter medications may be covered at no cost to you as part of a Step Therapy (See section on Utilization Management Program for more information). Examples of drugs that can be covered include the following:

- Prescription drugs
- Biological products
- Insulin
- Medical supplies for the injection of insulin (syringes, needles, alcohol swabs, and gauze)
- Vaccines

The actual drugs covered by each Medicare Drug Plan are determined by the Plan.

What Drugs Are Covered By <Part D Plan>?

<Part D Plan> has a formulary that lists all drugs that we cover. These drugs are covered as long as the prescription is filled at <Part D Plan> network pharmacies or through our mail order pharmacy service. Finally, for certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 5.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 1 ("<Part D Plan> Basics") for more information about filling prescription at out-of-network pharmacies.

<Part D Plan>'s Formulary

A formulary is a list of drugs selected by <Part D plan> in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. <Part D Plan> will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a <Part D Plan> network pharmacy, and other plan rules are followed.

Both brand-name drugs and generic drugs are included on our formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

How Do I Find Out What Drugs Are On <Part D Plan>'s Formulary?

To get a copy of our formulary, please visit our Web site at <Web site address>. You may also call Customer Service at <Toll-free number>, <Days and hours of operation>. TTY/TDD users should call <Toll-free TTY/TDD number>.

[What Are Drug Tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your <co-insurance/co-payment> depends on which drug tier your drug are in. The table below shows the <co-insurance/co-payment> amount you pay for each tier when you are in your initial

coverage level. (See "How Much Do I Pay for My Prescriptions?" on page <page number> for more information about the initial coverage level.)

Drug Tier	Retail Co-payment (30-day supply)	Mail-Order Co-payment (90-day supply)
<Tier Name 1>	<Insert co-pay>	<Insert co-pay>
<Tier Name 2>	<Insert co-pay>	<Insert co-pay>
<Tier Name 3>	<Insert co-pay>	<Insert co-pay>

You can ask us to make an exception to your drug's tier placement. See "How Do I Request an Exception to <Part D Plan>'s Formulary?" on page <page number> for more information.]

Can <Part D Plan>'s Formulary Change?

We may add or remove drugs from our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. We will send written notice of changes to our formulary to all <Part D Plan> members who are using a particular drug. This notice will be sent at least 60 days before the change will take effect. However, if a drug is removed from our formulary because the drug has been recalled from the market, a notice will not be given. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

You can call Customer Service at <Toll-free number>, <Days and hours of operation> to find out if your drug is on our formulary or to request a copy of our formulary. TTY/TDD users should call <Toll-free TTY/TDD number>. You can also get updated information about the drugs covered by <Part D Plan> by visiting our Web site at <Web address>.

What If My Drug Is Not On The Formulary?

If your prescription is not listed on our formulary, you should first contact Customer Service to be sure it is not covered. You can contact Customer Service at <Toll-free number>, <Days and hours of operation>. TTY/TDD users should call <Toll-free TTY/TDD number>.

If Customer Service confirms that we do not cover your drug, you have three options:

- <Part D Plan> can help you find another drug to treat your medical condition that is part of <Part D Plan>'s formulary; or
- You can ask us to make an exception and cover your drug. See "How Do I Request An Exception?" on page <page number> for more information.
- You can pay out-of-pocket for the drug and request that the plan reimburse you. See Section 7 for more information on how to request an appeal.

If you recently joined <Part D Plan> and learn that we do not cover a drug you were taking when you joined our plan, you may be able to receive a one-time fill of that prescription. You can receive a one-time fill of the non-covered drug if one of the following applies:

- You didn't know that your drug wasn't covered by <Part D Plan>, or
- You knew it wasn't covered but you didn't know that you could request an exception to <Part D Plan>'s formulary.

After your one-time fill, <Part D Plan> will work with you to help you find another drug to treat your medical condition that is covered by <Part D Plan>. If we cannot find another drug for you, we will help you file a request for an exception to our formulary. *[If Plan does not use "first fill" method, describe in sufficient detail how your Plan will stabilize the member's prescription drug needs.]*

In some cases, <Part D Plan> will contact you if you are taking a drug that is not on our formulary. We will let you know that your drug is not covered and can help you find another drug to treat your medical condition that is part of <Part D Plan>'s formulary. [*Plan should describe their drug transition policy.*]

How Can I Request An Exception To <Part D Plan>'s Formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, <Part D Plan> limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- [*Plans without tiered cost sharing should omit this bullet.*] You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a <Highest Tier Name> drug, you can ask us to cover it as a <Lower Tier Name> instead. This would lower the <coinsurance/co-payment> amount you must pay for your drug.

Generally, <Part D Plan> will only approve your request for an exception if the alternative drugs included on the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

In most circumstances, if we do approve your request for an exception, the exception is good for the rest of the year.

[Plans must describe the process for filing an exception.]

Once an exception request is approved, it is valid for the remainder of the plan year so long as your physician continues to prescribe the drug for you and it continues to be safe and effective for treating your condition.

Drug Exclusions

[*Plans: alter the exclusion list as necessary if this EOC is for your enhanced prescription benefit.*]

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs or categories of drugs are called "exclusions" and include:

- Nonprescription drugs, unless they are part of a step therapy
- Drugs when used for anorexia, weight loss, or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- 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
- Benzodiazepines

In addition, a Medicare Prescription Drug Plan cannot cover a drug if the drug would be available under Medicare Part A or Part B. See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B. Some drugs are covered under Medicare Part B in some cases and under <Part D Plan> in other cases. In general, your pharmacist or provider will determine whether to bill Medicare Part B or <Part D Plan> for the drug in question.

[*Plans: add the following sentence if this EOC is for your enhanced prescription benefit and you cover non-Part D drugs as part of your benefit.*

<Part D Plan> offers additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your total out of pocket expenditure (that is, the amount you pay does not help you obtain catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs. <*Plans should insert their cost-sharing structure for Non-Part D drugs covered under their enhanced prescription benefit.*> Please refer to your formulary to find out which drugs we are offering additional coverage for or call Customer Service if you have any questions.]

[Other Member Items & Services

[*If applicable, Plan should discuss, in detail, any other health-related benefits, such as discounts on over-the-counter drugs (OTCs) or vitamins]*]

How Much Do I Pay For Drugs Covered By <Part D Plan>?

[*Plans should revise this section, as needed, so that it accurately describes the costs and structure of the Plan.*]

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. See Section 2 "Extra Help with Drug Plan Costs for People with Limited Income and Resources" and the **Important Notice** you received with this document for more information.

When you fill a prescription for a covered drug, you pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage level, coverage gap, catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Your drug costs for each coverage level are included in the chart below.

[Chart below summarizes Standard Coverage and is provided only as an example.]

<table>
<tr><th>Coverage Level</th><th>When your total drug cost for the year is:</th><th colspan="2">Amount You Pay and Amount <Part D Plan> Pays</th></tr>
<tr><td>Annual Deductible</td><td>$0 to $<AD></td><td colspan="2"><b>You pay 100% ($<AD>)</td></tr>
<tr><td>Initial Coverage</td><td>$<AD>.01 to $<ICL></td><td><b>You pay approximately 25% ($<.25*ICL>)</td><td><Part D Plan> pays approximately 75% ($<.75*ICL>)</td></tr>
<tr><td>Coverage Gap*</td><td>$<ICL> to $<CCT></td><td colspan="2"><b>You pay 100% ($<CCT-ICL>)</td></tr>
<tr><td>Catastrophic Coverage</td><td>$<CCT>.01 and greater</td><td>You pay the greater of $2, $5 or 5%</td><td><Part D Plan> pays approximately 95%</td></tr>
</table>

* Your coverage gap may be different if you have other insurance that pays part of your prescription drug costs.

As the chart shows, you will pay a yearly **deductible** of $<deductible amount>. This is the amount you will have to pay each year before we start to pay for part of your drug costs. After you meet your deductible of $<deductible amount>, you will reach the initial coverage level.

During the **initial coverage** level, <Part D Plan> will pay part of the costs for your covered drugs and you pay the other portion. The amount you pay when you fill a covered prescription is called the <**co-insurance/co-payment**>. Your <co-insurance/co-payment> will vary depending on the drug and on whether you get the drug at a <Part D Plan> pharmacy or through our mail order service.

[Drug Tier	Retail Co-payment (30-day supply)	Mail-Order Co-payment (90-day supply)
<Tier Name 1>	<Insert co-pay>	<Insert co-pay>
<Tier Name 2>	<Insert co-pay>	<Insert co-pay>
<Tier Name 3>	<Insert co-pay>	<Insert co-pay>]

[*Plans should discuss, in detail, how the initial coverage limit is determined. For example, in a standard Plan, the Plan could describe the initial coverage limit as* "Once your total drug costs reach $2,250, you will then have a gap in your coverage." *In a non-standard Plan, where initial coverage limit is determined by the amount the Plan is paying, the Plan could describe the initial coverage limit as* "Once <Part D Plan> has paid $<ICL>, you have reached your initial coverage limit and there is a gap in your coverage."]

[This means that, unless you have other insurance coverage, you will have to pay the full amount for your drugs during this **coverage gap**.]

[*Plans that provide coverage after the initial coverage limit: explain in detail the coverage you provide between the ICL and the catastrophic threshold*.]

When the total amount you have paid toward your deductible, co-payments, and coverage gap reaches $<TrOOP>, you will qualify for catastrophic coverage. We will then pay approximately <95% of your drugs costs and you will pay the greater of $2, $5, or 5%.[*Plans: Insert the appropriate catastrophic coverage amount if different*.]> (See "How to I qualify for catastrophic coverage?" below for more information.)

Finally, if you have other insurance coverage, please see Section 6 "If You Have Other Prescription Drug Coverage" to see how your other insurance coverage will affect the amounts you will have to pay for covered drugs under our Plan.

How Do I Qualify For Catastrophic Coverage?

All Medicare Prescription Drug Plans, including <Part D Plan>, include catastrophic coverage for people with high drug costs. In order to qualify for this catastrophic coverage, you (or an individual or organization on your behalf) must spend at least $<TrOOP amount> out-of-pocket for the year. When you reach the catastrophic coverage level, <Part D Plan> will pay

approximately <95% and you will pay the greater of $2, $5 or 5% of the cost for your covered drugs.[*Plans: Insert the appropriate catastrophic coverage amount if different.*]>

[*Plans: add the following sentence if this EOC is for your enhanced prescription benefit and you cover non-Part D drugs as part of your benefit.*

Note: As mentioned earlier <Part D Plan> offers additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your total out of pocket expenditure (that is, the amount you pay does not help you obtain catastrophic coverage).]

How Is Your Out-Of-Pocket Cost Calculated?

[*Plans should adjust the language below, as necessary, to describe applicable deductibles, co-insurance/co-payments, initial coverage limits, etc.*]

Payments that count towards your out-of-pocket costs for reaching catastrophic coverage are:

- Your annual deductible
- Your co-insurance or co-payments in the initial coverage level
- Any payments you make during the coverage gap

When you have spent a total of $<TrOOP amount> for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level.

Generally, if you do not have other prescription drug coverage, you will qualify for catastrophic coverage when your total drug costs for the year reach $<CCT>.

If another person or an organization helps you pay for your prescription drug costs, the payments made for you may count as your out-of-pocket costs and help qualify you for catastrophic coverage. Please see below for more information about what types of assistance count as your out-of-pocket costs.

What Type Of Prescription Drug Payments Count Toward My Out-Of-Pocket Costs?

The following types of payments for prescription drugs will count toward your out-of-pocket costs and help qualify you for catastrophic coverage:

- Co-insurance or co-payments for prescription drugs on <Part D Plan>'s formulary;

- Co-insurance or co-payments for prescription drugs that were not on <Part D Plan>'s formulary, but by a coverage determination, the exceptions process, or a special appeal through <Part D Plan> were determined to count towards your out-of-pocket costs; and
- Any co-insurance or co-payments made at an out-of-network pharmacy in accordance with <Part D Plan>'s out-of-network access rules.

Purchases that will not count toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by <Part D Plan>;
- [*Plans: add the following sentence if this EOC is for your enhanced prescription benefit and you cover non-Part D drugs as part of your benefit*. Certain prescription drugs covered by us but are not normally covered in a Medicare Prescription Drug Plan.
- Over-the-counter drugs; and
- Vitamins

Who Can Pay For Your Prescription Drugs, And How Do These Payments Apply To Your Out-Of-Pocket Costs?

Except for your premium payments, any payments you make count toward your out-of-pocket costs and will help qualify you for catastrophic coverage. In addition, when the following individuals or organizations pay your prescription drug costs, these payments will count toward your out-of-pocket costs:

- Family members;
- Qualified state pharmaceutical assistance programs (SPAPs);
- Medicare programs to give extra help with prescription drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, payments usually will not count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans; and
- Similar third party arrangements (e.g., TRICARE, Workers Compensation).

If you have coverage from a third party that pays part of your out-of-pocket costs, you must disclose this information to <Part D Plan>. An example of third party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

<Part D Plan> will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. In addition, every month you purchase covered prescription drugs through <Part D Plan>, you will receive an Explanation of Benefits from <Part D Plan> that shows your out-of-pocket cost amount to date.

What Happens When I Reach The Catastrophic Coverage Level?

Once your total deductible, co-payments, and coverage gap payments reach $<TrOOP>, you will qualify for catastrophic coverage. You will be responsible for <the greater of $2, $5, or 5% of your drug costs [*Plans: Insert the appropriate catastrophic coverage amount if different.*]> for the rest of the year. Once you have reached the catastrophic coverage level, there is no limit to the amount <Part D Plan> will pay for your covered drugs.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will receive each month you use your <Part D Plan> prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount <Part D Plan> has paid for your drugs.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of item(s) or service(s) you received during the month, as well as the amount you paid and the amount <Part D Plan> paid for each item or service;
- Information about how to appeal <Part D Plan>'s decisions and how to request an exception to the <Part D Plan>'s formulary;
- A description of any changes to <Part D Plan>'s formulary;
- A summary of your <Part D Plan> coverage this year, including information about:
    - **Your annual deductible:** The Explanation of Benefits will tell you how much you have paid toward your annual deductible.
    - **Your initial coverage limit:** The Explanation of Benefits will tell you how much <Part D Plan> coverage you have left before you reach the initial coverage limit.
    - **Your total out-of-pocket drug costs:** The Explanation of Benefits will tell you your total out-of-pocket costs for the year. It will also tell you how much more you need to pay to reach the catastrophic coverage level.

When Will I Receive An Explanation Of Benefits?

You will receive an Explanation of Benefits in the mail each month that you use the benefits provided by <Part D Plan>.

What Should I Do If I Haven't Received An Explanation Of Benefits Or If I Wish To Request One?

An Explanation of Benefits is also available upon request. To obtain a copy, please contact Customer Service at <Toll-free Phone Number> <Days and Hours of operation>. (TTY/TDD users should call <Toll-free TTY/TDD Phone Number>.)

How Does My Prescription Drug Coverage Work If I Go To A Hospital Or Skilled Nursing Facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, <Part D Plan> will cover your prescription drugs as long as they are not covered by Medicare Part A or Part B and are part of <Part D Plan>'formulary and purchased at a <Part D Plan> network pharmacy.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, Medicare Part A will pay for your prescription drugs for the first 100 days that you are in the facility. After the first 100 days, <Part D Plan> will cover your prescriptions as long as the skilled nursing facility's pharmacy is in <Part D Plan>'s pharmacy network. If the skilled nursing facility's pharmacy is NOT part of <Part D Plan>'s pharmacy network, you will be eligible for a special enrollment period. During your special enrollment period, you will be able to leave <Part D Plan> and join a new Medicare Prescription Drug Plan that includes your skilled nursing facility's pharmacy in its network. Please see Section 12 of this document for more information about leaving <Part D Plan> and joining a new Medicare Prescription Drug Plan.

Section 5: Drug Management Programs

What is Utilization Management?

For certain prescription drugs, <Part D Plan> has additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for <Part D Plan> to help us to provide quality care to our members. Examples of utilization management tools are described below: *[Plans must describe any and all applicable utilization management procedures, including any procedures that are not listed below.]*

- **Prior Authorization:** <Part D Plan> requires you to get prior authorization for certain drugs. This means that you will need to get approval from <Part D Plan> before you fill your prescription. If you don't get approval, <Part D Plan> may not cover the drug.
- **Quantity Limits:** For certain drugs, <Part D Plan> limits the amount of the drug that we will cover per prescription or for a defined period of time. For example, <Part D Plan> will provide up to <number of units> per prescription for <drug name>.
- **Step Therapy:** In some cases, <Part D Plan> requires you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, <Part D Plan> may require your doctor to prescribe Drug A first. If Drug A does not work for you, <Part D Plan> will then cover Drug B.
- **Generic Substitution:** When there is a generic version of a brand name drug available, <Part D Plan> network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the <Part D Plan> formulary. If your drug does have these additional restrictions or limits, you can ask <Part D Plan> to make an exception to our coverage rules. See the section, "How do I request an exception to <Part D Plan>'s formulary?" in Section 4 for more information.

Drug Utilization Review

<Part D Plan> conducts drug utilization reviews for all of our members to make sure that you are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, <Part D Plan> looks for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If <Part D Plan> identifies a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication Management Programs

<Part D Plan> offers medication management programs for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for <Part D Plan> by a team of pharmacists and doctors. We use these medication management programs to help us provide better care for our members. For example, these programs help us to make sure that our members are using appropriate drugs to treat their medical conditions and help us to identify possible medication errors.

<Part D Plan> offers several medication management programs for different types of members, including those listed below.

[Plans must describe each medication management program and its target audience.]

To learn more about our medication management programs, or to join a program, contact Customer Service at <Toll-free number>, <Days and hours of operation>. TTY/TDD users should call <Toll-free TTY/TDD number>.

Section 6: If You Have Other Prescription Drug Coverage

If you have Medicare and Medicaid

Beginning January 1, 2006, your prescription drug coverage will change. Medicare, not Medicaid, will pay for your prescription drugs. You will continue to receive your health coverage under Medicaid.

If you are a member of a State Pharmaceutical Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may receive help paying your premiums, deductibles, and co-payments. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction on page <page number> for more information.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (Medigap) policy **that includes coverage for prescription drugs**, you must contact your Medigap issuer and tell them you have enrolled in <Part D Plan>. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium. In addition, under certain circumstances, you may be able to purchase a different Medigap policy from the same company. Your Medigap issuer cannot charge you more based on any past or present health problems.

You should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you do not receive this letter, please contact your Medigap issuer.

If you are a member of an employer or retiree group

If you currently have prescription drug coverage through your employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with <Part D Plan>. In general, if you are currently employed, the prescription drug coverage you receive from us will be secondary to your employer or retiree group.

You should have received a letter in the fall of 2005 from you employer or retiree group indicating whether or not your prescription drug coverage is *creditable* (meaning whether or not it covers at least as much as Medicare's prescription drug plan coverage) and the options available to you. If you did not receive this letter, please contact your benefits administrator.

If you are enrolled in a Medicare-approved drug discount card program

If you are a member of a Medicare-approved drug discount card program, you may continue to use your card to receive discounts on your prescription drugs until the effective date of your enrollment in <Part D Plan> or until May 15, 2006 (whichever comes first).

If you are a member of a Medicare-approved drug discount card and are receiving up to $600 credit in help paying for your prescription drugs, you will be able to use any remaining credit you have towards your prescription drug purchases until the effective date of your enrollment in <Part D Plan> or until May 15, 2006 (whichever comes first).

If you are enrolled in a non-Medicare approved drug discount card program

If you are a member of a drug discount card program that is not Medicare-approved, please contact your drug card issuer to determine what benefits are available to you. Any amount you pay for drugs while using a discount card will not count towards the <Part D Plan>'s deductible or your out-of-pocket expenses.

SECTION 7 Appeals and grievances: what to do if you have complaints

Appeals and grievances: What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Customer Service at the number <on the cover of this booklet / listed in Section 1>.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from <Part D Plan> or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make.

An "**appeal**" is the type of complaint you make **when you want us to reconsider and change a decision we have made about what prescription drug benefits are covered for you or what we will pay for a prescription drug.** For example, if we refuse to cover or pay for a prescription drug you think we should cover, you can file an appeal. If <Part D Plan> refuses to give you a prescription drug you think should be covered, you can file an appeal. If <Part D Plan> reduces or cuts back on the prescription drugs you have been receiving, you can file an appeal. If you think we are stopping your prescription drug coverage too soon, you can file an appeal.

A "grievance" is the type of complaint you make **if you have any other type of problem with <Part D Plan> or one of our network pharmacies.** For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or getting the information you need, or the cleanliness or condition of a network pharmacy.

This section tells you how to appeal

This section of part of Section 7 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to appeal our decision. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting. Problems getting a Part D prescription drug that you believe we should provide include the following situations:

- If you are not getting a prescription drug that you believe may be covered by <Part D Plan>.
- If you have received a Part D prescription drug you believe may be covered by <Part D Plan> while you were a member, but we have refused to pay for.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a "formulary"). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the co-payment we require you to pay for a drug.
- You have requested an exception to our formulary or to the co-payment for a drug and we have denied your request.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.
- We do not make a decision on your request within the required time frame.

Requesting an appeal from <Part D Plan>.

If you are having a problem getting a Part D benefit or payment for a Part D prescription drug that you have already received, you can request an appeal. After we have made the initial coverage determination, there are five levels of appeal. At each level, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to ask for the next level of appeal if you want to continue requesting the benefit or payment. Each appeal level is discussed in greater detail in the section called "How does the appeals process work?" [see page xx].

This section tells you how to file a grievance about any other type of problem you have with <Part D Plan> or one of our plan providers

This part of Section 7 explains how to file a grievance.

A grievance is different from an appeal because usually it will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the appeals process discussed above).

What types of problems might lead to you filing a grievance?

- If you feel that you are being encouraged to leave (disenroll from) <Part D Plan>.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to make a decision within the required time frame.
- Failure to forward your case to the independent review entity if we do not make a decision within the required time frame.

In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

Filing a grievance with <Part D Plan>

If you have a grievance, we encourage you to first call Customer Service at the number <on the cover of this booklet/shown in Section 1>. We will try to resolve any complaint that you might have over the phone**.** If you request a written response to your phone complaint, we will respond to you in writing. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this [*insert name of your grievance procedure, then insert description of the procedures (including time frames) and instructions about what members need to do if they want to use it. Be sure to describe expedited grievance time frames for grievances about decisions to not conduct expedited organizational determinations or reconsiderations or to take extensions on initial decisions or appeals*]**.** We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

Detailed information about how to request an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to appeal a decision by us not to cover or pay for all or part of a drug, vaccine, or other Part D benefit. There are five levels to the appeals process. This section goes through each step in detail.

What kinds of decisions can be appealed?

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not reimburse you for a Part D drug that you paid for. In addition, if you think we should have paid or reimbursed you more than you received, or the amount you are paying is more than you are supposed to pay under the plan, you can appeal. Finally, if we deny your exception request, you can appeal. Here are some examples of situations where you might want to file an appeal:

- If you are not getting a prescription drug that you believe may be covered by <Part D Plan>.
- If you have received a Part D prescription drug you believe may be covered by <Part D Plan> while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a "formulary"). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the co-payment we require you to pay for a drug.
- You have requested an exception to our formulary or to the co-payment for a drug and we have denied your request.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.
- We do not make a decision on your request within the required time frame.

Please Note: *If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment we require you to pay for the drug.*

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

Moving from one level to the next. At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

"Initial decision" vs. "making an appeal." Whenever you ask for a Part D benefit, the first step is called an "initial decision" or a "coverage determination." If you are unhappy with the initial decision, you can ask for an appeal, which is called a redetermination. There are also four other levels of appeal that an enrollee may request.

Who makes the decision at each level. You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make an initial decision. If our initial decision is to turn down your request (in whole or in part), you can go on to the first level of appeal by asking us to review our initial decision. If you are still dissatisfied with the outcome, you can ask for further review. If you do, **your appeal is then sent outside of <Part D Plan>, where people who are not connected to us conduct the review and make the decision.** After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Initial Decision: <Part D Plan> makes an "initial decision" about your Part D prescription drug, or about paying for a Part D prescription drug you have already received.

What is an "initial decision"?

The "initial decision" made by <Part D Plan> is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact <Part D Plan> and ask us for an initial coverage decision. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. (This "initial decision" is sometimes called a "coverage determination.") If our initial decision is to deny your request (this is sometimes called an "adverse coverage determination"), you can "appeal" the decision by going on to Appeal Level 1 (see below). If we fail to make a timely "initial decision" on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

- You ask us to pay for a prescription drug you have already received; this is a request for an "initial decision" about payment. You can call us at <phone number> to get help in making this request.

- You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"), this is a request for a "formulary exception." A "formulary exception" is a type of "initial decision." You can call us at <phone number> to ask for this type of decision.

- You ask for an exception to our plan's utilization management techniques. These are also considered to be requests for "formulary exceptions," and are a type of "initial decision." You can call us at <phone number> to ask for this type of decision.

- You ask for a non-preferred Part D drug at the preferred cost level, this is a request for a "tiering exception." A "tiering exception" is a type of "initial decision." You can call us at <phone number> to ask for this type of decision.

- You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the plan. You can call us at <phone number> to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

When we make an "initial decision," we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of <Part D Plan> apply to your specific situation. This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by <Part D Plan>, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by <Part D Plan>).

Who may ask for an "initial decision" about a Part D benefit or payment?

You can ask us for an initial decision yourself, or your prescribing physician or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at <Plan address>. You can call us at < Plan phone number and TTY/TDD number> to learn how to name your appointed representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can 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. You may want to contact <Legal Agency Name> at <phone number, and TTY/TDD # if one is available>.

"Standard decisions" vs. "fast decisions"

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover a Part D prescription drug can be a "standard decision" that is made within the standard time frame (typically within 72 hours; see below), or it can be a "fast decision" that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should mail or deliver a request in writing to the following address: <Part D Plan>, <Plan address>.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a "fast" decision (rather than a "standard" decision) by calling us at <phone number> (for TTY/TDD, call <phone number>). Or, you can deliver a written request to <Part D Plan>, <Plan address>, or fax it to [fax number]. [Specify instructions for delivering requests that are made outside of regular weekday business hours.] Be sure to ask for a "fast," "expedited," or "24-hour" review.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 72 hours; see below).

What happens when you request an "initial decision?"

What happens, including how soon we must decide, depends on the type of decision.

1. *For a <u>standard</u> initial decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

   Generally, we must make our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, an exception from utilization management rules – such as dosage or quantity limits or step therapy requirements—or a tiering exception), we must make our decision no later than 72 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

   We will tell you in writing of our initial decision concerning the prescription drug you have requested. You will receive this notification when we make our decision under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

   If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. *For a <u>fast</u> initial decision about a Part D drug that you have not received.*
   If you receive a "fast" review, we will give you our decision within 24 hours after you or your doctor ask for a "fast" review—sooner if your health requires. If your request involves a request for an exception, we must make our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

   We will tell you in writing of our initial decision concerning the prescription drug you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

   If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

   If we do not grant your or your physician's request for a "fast" review, we will make our decision within the "standard" 72- hour time frame discussed above. If we tell you about our decision not to provide a "fast" review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a "fast" review, and will explain that we will automatically give you a fast decision if you get a doctor's support

for a "fast" review.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

   We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we have received your physician's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

2. *For a fast decision about a Part D drug that you have not received.*

   We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we have received your physician's "supporting statement."

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If any initial decision does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1)

Appeal Level 1: If we deny part or all of your request in our initial decision, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."

Please call us at <Plan phone number> if you need help with filing your appeal. You may ask us to reconsider our initial decision, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to people at our organization who were not involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to

decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision*. Please see the discussion under, "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision." [If you have your appeals sent to a different office than where your coverage determinations are sent, you should mention that while the process for deciding on a standard or fast appeal is the same as in the case of an initial decision, the place where the appeal is sent is different–refer them to "What if you want a 'fast' appeal" later in this section for more information.]

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information. You can give us your additional information in any of the following ways:

WRITE	<Part D Plan>, <Plan address>.
FAX	<Plan phone number>.
CALL (if it is a "fast" appeal)	<Plan phone number>.
IN PERSON	<Plan physical address>.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at <Plan phone number>, <Part D Plan>, <Plan address>. [*if a fee is charged, insert:* We are allowed to charge a fee for copying and sending this information to you.]

How do you file your appeal of the initial decision?

The rules about who may file an appeal are almost the same as the rules about who may ask for an "initial decision." Follow the instructions under "Who may ask for an 'initial decision' about medical care or payment?" The only difference between asking for an initial decision and the first level of appeal is that your prescribing physician may only request a "fast" appeal, unless you appoint (or have already appointed) your prescribing physicians as your appointed representative.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our initial decision. We can give you more time if you have a good reason for missing the deadline. To file a "standard" appeal, you can send the appeal to us in writing at <Part D Plan>, <Plan address>. **[***If the plan chooses to accept oral requests for redetermination, insert the following:* To file a "standard" appeal, you can call us at the telephone number <on the cover of this booklet/shown in Section 1> or send the appeal to us in writing at <the address above> or <Part D Plan>, <Plan address>.**]**

To file a "fast" appeal, you can call us at the telephone number <on the cover of this booklet/shown in Section 1> or send the appeal to us in writing at <the address above> or <Part D Plan>, <Plan address>.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" initial decision. If you want to ask for a "fast" appeal, please follow the instructions under "Asking for a fast decision." [Remember, that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.] [If you have appeals sent to a different office than where your coverage determinations are sent, you should mention that while the process for deciding on a standard or fast appeal is the same as the process at the initial decision level, the place where the appeal is sent is different; also include instructions for where to send appeal requests.]

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.*

   After we receive your appeal, we have up to 7 calendar days to make a decision, but will make it sooner if your health condition requires us to. If we do not tell you our decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

2. *For a fast decision about a Part D drug that you have not received.*

   After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires us to. If we do not tell you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must send payment to you no later than 30 calendar days after we receive your request to reconsider our initial decision.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal -- or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization to review your case. This independent review organization contracts with the Federal government and is not part of <Part D Plan>.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. [*Insert if you charge a fee:* We are allowed to charge you a fee for copying and sending this information to you.]

How soon must you file your appeal?

You must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to [*include instructions about where and how to file appeal requests, including* <name of independent review organization> and <Plan address>.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" initial decision. If you want to ask for a "fast" appeal, please follow the instructions under "Asking for a fast decision." [Remember that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, the IRE will automatically treat you as eligible for a fast appeal.]

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it received your request to make a decision.
2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it receives the request to make a decision.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must pay within 30 calendar days from the date we receive notice reversing our initial decision. We will also send the independent review organization a notice that we have abided by their decision.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our initial decision. We will also send the independent review organization a notice that we have abided by their decision.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our initial decision. We will also send the independent review organization a notice that we have abided by their decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is $<insert amount*>or more. *Note: CMS will provide the dollar threshold for all organizations when the information is available in September.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to [*include instructions about where and how to file appeal requests with the ALJ Field Office.*]
During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than $<insert amount*>. If the dollar value is less than $<insert amount*>, you may not appeal any further. *Note: CMS will provide the dollar threshold for all organizations when the information is available in September.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to that point, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we receive notice reversing our initial decision.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our initial decision.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our initial decision.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by a Medicare Appeals Council

The Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you can request review by the Council.

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we receive notice reversing our initial decision.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our initial decision.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our initial decision.

If the Council decides against you:

If the amount involved is $<insert amount*> or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than $<insert amount*>, the Council's decision is final and you may not take the appeal any further. *Note: CMS will provide the dollar threshold for all organizations when the information is available in September.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount is $[insert amount*] or more, you may ask a Federal Court Judge to review the case. *Note: CMS will provide the dollar threshold for all organizations when the information is available in September.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we receive notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you within 30 calendar days from the date we receive notice reversing our initial decision.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our initial decision.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our initial decision.

If the Judge decides against you:

The Judge's decision is final and you may not take the appeal any further.

SECTION 8 Leaving <Part D Plan> and Your Choices for Continuing Prescription Drug Coverage after You Leave

What Is "Disenrollment"?

"Disenrollment" from <Part D Plan> means ending your membership with us. **Disenrollment can be** voluntary **(your own choice)** or involuntary **(not your own choice):**

- You might leave <Part D Plan> because you have decided that you *want* to leave. You can decide to leave for any reason during specified times (See Number 4 below).
- There are also a few situations where you would be *required* to leave. For example, you would have to leave <Part D Plan> if you move out of our geographic service area or if <Part D Plan> no longer offers prescription drug coverage. We are not allowed to ask you to leave the Plan because of your health.

Whether leaving the Plan is your choice or not, this section explains your prescription drug coverage choices after you leave and the rules that apply.

Until Your Prescription Drug Coverage With <Part D Plan> Ends, Use Our Network Pharmacies To Fill Your Rx

If you leave <Part D Plan>, it takes some time for your prescription drug coverage to end and your new prescription drug coverage to begin (we discuss when the change takes effect later in this section). You can choose to disenroll from your current plan from November 15 through December 31 of every year. Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can disenroll from your plan at other times. After you request to disenroll, your plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through <Part D Plan>'s network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy {*Optional:* or through our mail order pharmacy service.}, are listed on our formulary, and follow other plan rules.

If you have any questions about your prescription drug coverage with <Part D Plan>, please call Customer Service at <Phone Number> <Days and Hours of Operation> (TTY/TDD users should call <TTY/TDD Phone Number> <Days and Hours of Operation>).

What Are Your Options For Obtaining Prescription Drug Coverage If You Leave <Part D Plan>?

If you leave <Part D Plan>, one choice for obtaining prescription drug coverage is to join another Medicare Prescription Drug Plan. You also have the choice of joining a Medicare Advantage Plan with prescription drug coverage *if* this type of plan is available in your area, they are accepting new members, and you meet the eligibility requirements of the plan.

Medicare Prescription Drug Plan. You may choose to join another Prescription Drug Plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another Prescription Drug Plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and reside in the service area of the Prescription Drug Plan.

Medicare Advantage Prescription Drug Plan (MA-PD). If you choose to join a Medicare Advantage Plan that offers prescription drug coverage, then you must obtain your Medicare prescription drug cover through that Medicare Advantage Plan. For more information on joining a Medicare Advantage Plan in your area, please contact 1-800-MEDICARE (TTY/TDD users call 1-877-486-2048) or visit www.medicare.gov.

You may also be able to get back the prescription drug coverage you had before you enrolled in <Part D Plan>. Please contact your previous Prescription Drug Plan for more information.

When Can You Disenroll / Switch Prescription Drug Plans?

In general, you may only disenroll or switch prescription drug plans under certain circumstances. You can switch your Prescription Drug Plan during the following periods:

Initial Enrollment Period

The initial enrollment period for prescription drug coverage is the period during which an individual is *first* eligible to enroll in a Prescription Drug Plan.

In 2005: An individual who becomes eligible for prescription drug coverage prior to January 31, 2006, has an initial enrollment period from November 15, 2005 through May 15, 2006.

February 2006: An individual who becomes eligible for prescription drug coverage in February 2006 has an initial enrollment period from November 15, 2005 through May 31, 2006.

After March 2006: An individual who becomes eligible for prescription drug coverage after March 2006 has an initial enrollment period that begins 3 months before the month the individual becomes eligible for Medicare Part A and ends 3 months after the first month of eligibility.

If you join a Prescription Drug Plan in 2005 (for coverage year 2006), your effective date of coverage will be January 1, 2006.

If you join a Prescription Drug Plan after January 1, 2006, your coverage will be effective on the first day of the month after the month in which you join. For example, if you join on April 10th, your effective coverage date will be May 1st.

You will have to pay a late enrollment fee if your initial enrollment period ends, and for a period of 63 days or longer if you:

- were eligible for prescription drug coverage,
- did not have credible prescription drug coverage, and
- were not enrolled in a Prescription Drug Plan or Medicare Advantage Prescription Drug Plan.

Note: *Please refer to Section 3 for more information.*

If you are currently enrolled in a Medigap plan with prescription drug coverage, please read below:

If you have a Medigap (Medicare Supplement) Policy with prescription drug coverage, you should be receiving a letter in the fall of 2005 from your Medigap issuer explaining your options and explaining how the removal of drug coverage from your Medigap plan will affect your premiums. If you enroll in a Prescription Drug Plan during the initial enrollment period (November 15, 2005 through May 15, 2006), you will also be guaranteed the right to switch to a different Medigap plan without drug coverage from the same issuer that sold you your Medigap policy with the drug coverage. If you do not receive this letter, contact the issuer of your Medigap policy.

Annual Coordinated Election Period

During the Annual Coordinated Election Period, anyone with prescription drug coverage may disenroll from any Prescription Drug Plan and join another Prescription Drug Plan, or join a Medicare Advantage Plan with prescription drug coverage, or choose not to have any Medicare prescription drug coverage.

For coverage beginning in 2006, the annual coordination election period begins on November 15, 2005 and ends on May 15, 2006.

For coverage beginning in 2007 and afterwards, the annual coordinated election goes from November 15 through December 31 of each year.

Please remember, if during this election period you disenroll from <Part D Plan> and do not enroll in another Prescription Drug Plan or Medicare Advantage Plan with prescription drug coverage during this election period, you may have to pay a higher premium for Medicare prescription drug coverage in the future.

If you join another Prescription Drug Plan during the Annual Coordinated Election Period, your enrollment in <Part D Plan> will end on December 31 and your enrollment in the new Plan will be effective on January 1st of the following year.

Exception for January 1, 2006 through May 15, 2006. If you disenroll from <Part D Plan> to join another Prescription Drug Plan between January 1, 2006 and May 15, 2006, your coverage will be effective on the first day of the month after the month in which you join the Plan.

Special Enrollment Period

Generally, you may not disenroll from <Part D Plan> and enroll in a new Prescription Drug Plan during other times of the year *unless* you qualify for a Special Enrollment Period. In order to qualify for a Special Enrollment Period, one of the following must apply to you:

- <Part D Plan> no longer offers prescription drug coverage in the area where you live.
- You decide to move outside <Part D Plan>'s service area.
- You have an involuntary loss of prescription drug coverage. Please note that failure to pay your premium does not qualify as an involuntary loss of prescription drug coverage.
- You were not adequately informed about your loss of credible prescription drug coverage, or you were not adequately informed that you never had credible prescription drug coverage.
- Your enrollment in <Part D Plan> was unintentional, inadvertent, or a mistake, because of the error, misrepresentation or inaction of a Federal employee, or a person acting upon the Federal government's behalf.
- You receive benefits from both Medicare and Medicaid programs.

- <Part D Plan>'s contract with the Centers for Medicare & Medicaid Services is terminated.
- You were a member of a Medicare Advantage Plan with prescription drug coverage and decided join a Prescription Drug Plan during the Medicare Advantage Plan's Open Election Period.
- You are able to demonstrate that <Part D Plan> has substantially violated a material provision in its contract. This includes, but is not limited to:
- If <Part D Plan> failed to provide you with prescription drug coverage in a timely manner.
- If <Part D Plan> failed to provide your prescription drug coverage with applicable quality standards.
- You are able to demonstrate that <Part D Plan> misrepresented itself in its marketing.

In the event that you are eligible for a Special Enrollment Period, the Centers for Medicare & Medicaid Services will determine the time frame for you to enroll in another Plan. If you feel you qualify for a Special Enrollment Period, please call Customer Service and we will assist you.

How Do You Disenroll?

If you wish to leave <Part D Plan>, and you are not enrolling in another Prescription Drug Plan, you will need to submit a disenrollment request. You can write or fax a letter to us *{Optional:* insert Internet option*}* and send it to Customer Service at <Plan address> or to our fax number at <Plan fax number>. Be sure to sign and date your letter *{Optional:* form*}*. *[Include if applicable:* To obtain a copy of this form, please call Customer Service at <Phone Number> <Days and Hours of operation> (TTY/TDD users should call <TTY/TDD Phone Number> <Days and Hours of Operation>).*]* You may only disenroll during the Annual Coordinated Election Period unless you qualify for a Special Enrollment Period.

If you are joining another Prescription Drug Plan, you must contact that Plan to request enrollment information. Once you are enrolled in your new Plan, your membership in <Part D Plan> will *automatically* end with no action required on your part. Your new Plan will tell you, in writing, the date when your prescription drug coverage in that Plan begins. Your prescription drug coverage with <Part D Plan> will end on that same day (this will be your "disenrollment date"). Remember, you are still a member of <Part D Plan> until your disenrollment date, and must continue to get your prescription drug coverage, as usual, through <Part D Plan> until the date your membership ends.

When Can <Part D Plan> Disenroll You?

<Part D Plan> can disenroll you for the following reasons:

- You are no longer eligible for Medicare prescription drug coverage.
- If <Part D Plan> is no longer contracting with Medicare or leaves your service area.
- When you move out of <Part D Plan>'s service area.
- You materially misrepresent third-party reimbursement.
- [*Insert, if applicable:* You fail to pay your Plan premium.]
- [*Insert, if applicable:* You engage in disruptive behavior, provided fraudulent information when you enrolled or abuse your enrollment card.]

If You Are No Longer Eligible For Medicare Prescription Drug Coverage

If you lose your eligibility for Medicare prescription drug coverage, <Part D Plan> can no longer offer you prescription drug coverage. In order to be eligible for prescription drug coverage under Medicare, you must have Part A and/or Part B, and reside in <Part D Plan>'s service area.

When <Part D Plan> Is No Longer Contracting With Medicare Or Leaves Your Service Area

If <organization or plan name> leaves the Medicare program or no longer offer prescription drug coverage in the service area where you live, we will notify you in writing. If this happens, your membership in <Part D Plan> will end, and you will have to enroll in another Medicare Prescription Drug Plan to continue your prescription drug coverage. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your prescription drugs in the usual way through <Part D Plan>'s network pharmacies until your membership ends.

Your choices include joining another Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage if these plans are available in your area and are accepting new members. Once we have notified you in writing that we are leaving the Medicare program or the area where you live, you may enroll in another plan (See Number 4 above for specific information on special enrollment periods)

<Part D Plan> has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract may be renewed each year. However, <Part D Plan> or CMS can decide to end the contract at any time. You will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

When You Move Out Of <Part D Plan>'s Service Area

If you plan to move, please call Customer Service at <Phone Number> (TTY/TDD users should call <TTY/TDD Phone Number>) to find out if the place you are moving to is in <Part D Plan>'s service area. If you move permanently out of our service area, you will need to leave ("disenroll" from) <Part D Plan>. An earlier part of this section tells about the choices you have if you leave <Part D Plan> and explains how to leave.

You Materially Misrepresent Third-Party Reimbursement

If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires <Part D Plan> to disenroll you. In addition, if you are disenrolled from <Part D Plan> for misrepresentation of third party reimbursement, <Part D Plan> has the right to decline you future enrollment in our Prescription Drug Plan.

[Insert, if applicable] You Fail to Pay <Part D Plan>'s Premium

If you fail to pay your Plan premium, <Part D Plan> has the right to disenroll you. <Part D Plan> will send you a written notice in an effort to collect the unpaid premium(s). Failure to comply with payment will result in disenrollment from <Part D Plan>.

In addition, if you are disenrolled from <Part D Plan> for failure to pay your premium, <Part D Plan> has the right to decline your future enrollment in our Prescription Drug Plan.

If you are disenrolled due to not paying your premium and you do not have drug coverage that, on average, is at least as good as standard Medicare prescription drug coverage for 63 days or longer, then you will pay a continuous period of higher premium the next time you enroll in a Prescription Drug Plan.

[Insert, if applicable] You Engage in Disruptive Behavior, Provide Fraudulent Information When You Enrolled, or Abuse Your Enrollment Card

You may be asked to leave <Part D Plan> in the following circumstances:

- If you behave in a way that seriously affects our ability to arrange or provide prescription drugs for you or for others who are members of <Part D Plan>. We cannot make you leave (i.e., disenroll from) <Part D Plan> for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in <Part D Plan>.
- If you let someone else use your Plan membership card to get prescription drugs for themselves or for others. Before we ask you to leave (i.e., disenroll from) <Part D Plan> for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.

We Cannot Ask You To Leave The Plan Because Of Your Health

No member of any Medicare Prescription Drug Plan can be asked to leave the Plan for any health-related reasons or the number of prescriptions a member takes. If you ever feel that you are being encouraged or asked to leave <Part D Plan> because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048), the national Medicare help line.

You Have The Right To Make A Complaint If We Ask You To Leave <Part D Plan>

If we ask you to leave <Part D Plan>, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 7 for more information.

Section 9 Your Rights and Responsibilities as a Member of <Part D Plan>

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 9, we explain your Medicare rights and protections as a member of <Part D Plan>. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. <Organization name> must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Customer Service at the number <on the cover of this booklet / listed in the Introduction>.

Your right to the privacy of your medical records and personal health information

There are Federal and State laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.
The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged 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 review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call Customer Service at the phone number <on the cover of this booklet / in the Introduction>.

Your right to get your prescriptions filled within a reasonable period of time

As explained in this booklet, you should get all of your prescriptions filled from a network pharmacy, that is, from pharmacies which contract with <Part D Plan>. You have the right to go to any network pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time. Section 2 explains how to use a network pharmacy to get your prescriptions filled.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to receive a detailed explanation from us if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Sections 10 and 11.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals are discussed in Sections 10 and 11, and grievances are discussed in the Introduction.
If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that members have filed *against* <organization name> in the past. To get this information, call Customer Service at the phone number <on the cover of this booklet/listed in the Introduction>.

Your right to get information about your drug coverage and costs

This booklet tells you what you have to pay for prescription drugs as a member of <Part D Plan>. If you need more information, please call Customer Service at the number <on the cover of this booklet/listed in the Introduction>. You have the right to an explanation from us about any bills you may get for drugs not covered by <Part D Plan>. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about **<organization name>, <Part D Plan>***, and network pharmacies*

You have the right to get information from us about <organization name> and <Part D Plan>. This includes information about our financial condition, about our network pharmacies, and about how <Part D Plan> compares to other Medicare Prescription Drug plans. To get any of this information, call Customer Service at the phone number <on the cover of this booklet/ listed in the Introduction>.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Service at the number <on the cover of this booklet / in the Introduction>. You can also get free help and information from [state-specific name of SHIP / your State Health Insurance Assistance Program, or SHIP] (the Introduction tells how to contact [state-specific name of SHIP / the SHIP in your state]). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections.* To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

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

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at <insert phone numbers for the Office of Civil Rights in all applicable states or regions>.

For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Customer Service at the number <on the cover of this booklet/listed in the Introduction>. You can also get help from <state-specific name of SHIP / your State Health Insurance Assistance Program, or SHIP> (the Introduction tells how to contact <state-specific name of SHIP / the SHIP in your state>).

What are your responsibilities as a member of <Part D Plan>?

Along with the rights you have as a member of <Part D Plan>, you also have some responsibilities. Your responsibilities include the following:

- Become familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you [*insert specifics about other information if applicable*] to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service at the phone number <on the cover of this booklet/listed in the Introduction> if you have any questions.
- Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to. Be sure to ask your health care provider(s) if you have any questions.
- Pay your plan premiums and any co-payments you may owe for the covered drugs you get. You must also meet your other financial responsibilities that are described in Section 3 of this booklet.
- Let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service at the phone number <on the cover of this booklet/listed in the Introduction>.

SECTION 10 Legal Notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The 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 (CMS). In addition, other Federal laws may apply and, under certain situations, the laws of the State(s) of <insert name or names of states> may apply.

Notice about nondiscrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like <organization name>, 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 receive Federal funding, and any other laws and rules that apply for any other reason.

[*You may include other legal notices, such as a notice about third party liability. These notices may only be added if they conform to Medicare laws and regulations and/or state laws that do not conflict with federal laws.*]

Section 11 Definitions of Some Words Used in This Booklet

[*You may insert definitions not included in this model and exclude model definitions not applicable to your contractual obligations with CMS or enrolled Medicare beneficiaries. If you use any of the following terms in your EOC, you must add a definition of the term, either in each section where you use it or here in Section 11 with a reference from the section where you use it.*]

For The Terms Listed Below, this Section either Gives A Definition Or Directs You To a Place In This Booklet That Explains The Term

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what drugs are covered for you or what we will pay for a drug. Section7 explains what appeals are, including the process involved in making an appeal.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Covered Drugs – The general term we use in this booklet to mean all of prescription drugs covered by <Part D Plan>. Covered services are listed in the Benefits Chart in Section 4.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage for any period 63 days or longer after the end of your initial enrollment period.

Customer Service – A department within <organization name> responsible for answering your questions about your membership, benefits, grievances, and appeals. See the introduction for information about how to contact Customer Service.

Disenroll or Disenrollment – The process of ending your membership in <Part D Plan>. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 8 discusses disenrollment.

Emergency Care – Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 discusses emergency services.

Evidence of Coverage and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your covered services, defines our obligations, and explains your rights and responsibilities as a member of the <Part D Plan>.

Formulary – A list of covered drugs provided by the plan.

Grievance – A type of complaint you make when your complaint would not be an appeal, but you have any other type of problem either with us or with one of our plan providers. Section 7 explains what grievances are and how to file one.

Late enrollment penalty – If you do not have creditable prescription drug coverage, you will have to pay a late enrollment penalty in addition to your monthly plan premium.

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

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

Medicare Advantage Plan-with Prescription Drug Coverage – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area.

Medicare prescription drug coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

"Medigap" (Medicare supplement insurance) policy – Many people who receive Original Medicare also buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

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

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

Non-network pharmacy – A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of <Part D Plan>. As explained in this booklet, most services you get from non-network pharmacies are not covered by <organization name> unless certain conditions apply. See section 1.

Preferred Pharmacy – A network pharmacy that offers covered Part D drugs at negotiated prices to Part D enrollees at lower cost-sharing levels than apply at another network pharmacy.

Prior authorization – Approval in advance to get drugs not on our formulary. Some services are covered only if your doctor or other plan provider gets "prior authorization" from <organization name>. Covered services that need prior authorization are marked in the formulary.

Service area – A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

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.