

Blue Cross MedicareRx (PDP) EVIDENCE OF COVERAGE

CORE Plan



This booklet is your Blue Cross MedicareRx (PDP) Prescription Drug Evidence of Coverage (EOC). For questions regarding your coverage please call customer service, Monday through Friday, from 8 a.m. to 9 p.m. EST at 1-866-470-6265. TTY/TDD users can call 1-877-247-1657.

A stand alone prescription drug plan with a Medicare contract.

Anthem 
Health. Join In. Blue Cross

EVIDENCE OF COVERAGE

January 1, 2012 – December 31, 2012

Your Medicare Prescription Drug Coverage as a Member of Anthem Blue Cross MedicareRx (PDP)

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

Customer Service:

For help or information, please call Customer Service or go to our plan website.

1-866-470-6265 (Calls to these numbers are free.)

TTY/TDD users call: 1-877-247-1657

Hours of Operation:

8 a.m. to 9 p.m. EST

Monday through Friday

This plan is offered by Anthem Blue Cross, referred to throughout the Evidence of Coverage as “we,” “us,” or “our.” Anthem Blue Cross MedicareRx (PDP) is referred to as “plan” or “your plan.”

A Medicare-approved Part D sponsor.

This information may be available in a different format, including other languages and large print. Please call Customer Service at the number listed above if you need plan information in another format or language.

Benefits, drug list, pharmacy network, premium and/or copayments/coinsurance may change upon renewal.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

Your 2012 Prescription Drug Benefit Chart
Premier 10/25/40 Plan
University of California – Core Plan
Effective January 1, 2012

Formulary	Premier 3 Tier – Open
Covered Services	What you pay

Initial Coverage

Below is your payment responsibility until the cost paid by you and the Coverage Gap Discount Program for your prescriptions reaches your True Out of Pocket costs of \$1,000.

Retail Pharmacy	per 30-day supply
<ul style="list-style-type: none"> • Generics, including Specialty Drugs • Select Generics 	\$10 copay \$0 copay for Select Generics
<ul style="list-style-type: none"> • Preferred Brands, including Specialty Drugs and Vaccines 	\$25 copay
<ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs 	\$40 copay
<ul style="list-style-type: none"> • Diabetic Supplies – insulin syringes 	\$25 copay
<ul style="list-style-type: none"> • Diabetic Supplies – alcohol swabs and gauze 	\$0 copay
<ul style="list-style-type: none"> • Preventive Immunizations 	\$0 copay

Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.

If you purchase more than a 30-day supply at one of the University of California retail pharmacies, you only pay the mail order copay shown below.

Mail Order Pharmacy	per 90-day supply
<ul style="list-style-type: none"> • Generics, including Specialty Drugs • Select Generics 	\$20 copay \$0 copay for Select Generics
<ul style="list-style-type: none"> • Preferred Brands, including Specialty Drugs and Vaccines 	\$50 copay
<ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs 	\$80 copay
<ul style="list-style-type: none"> • Diabetic Supplies – insulin syringes 	\$50 copay
<ul style="list-style-type: none"> • Diabetic Supplies – alcohol swabs and gauze 	\$0 copay
<ul style="list-style-type: none"> • Preventive Immunizations 	\$0 copay

A stand alone prescription drug plan with a Medicare contract.

Y0071_12_12509_ID09 06/08/2011

2012 Custom Premier 10/25/40 Plan University of California_Core Full Gap
 P3TBRO (10S)

09/26/2011

Covered Services	What you pay
<p>Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in this benefit chart. Please see “When can you use a pharmacy that is not in your plan’s network?” section of your Evidence of Coverage for complete information.</p>	
<p>Vaccine Coverage</p>	
<p>The up front costs for vaccines will vary based upon where the vaccine is purchased and administered. Some vaccines, such as Flu Vaccines, are paid under your Medicare Part B coverage. Vaccines that are covered by Medicare Part B are not covered by your Part D plan. Please see your Evidence of Coverage booklet for a complete explanation of your vaccine coverage.</p>	
<p>Catastrophic Coverage</p>	
<p>Your payment responsibility changes after the cost you have paid for prescription drugs and the amount of the Coverage Gap Discount reaches your True Out of Pocket cost of \$1,000.</p>	
<ul style="list-style-type: none"> • Generics, including Specialty Drugs 	<p>\$0 copay</p>
<ul style="list-style-type: none"> • Select Generics 	<p>\$0 copay for Select Generics</p>
<ul style="list-style-type: none"> • Preferred and Non-Preferred Brands including Specialty Drugs, Vaccines, and Non-Formulary Drugs 	<p>\$0 copay</p>
<p>Extra Covered Drug Group</p>	
<p>These are drugs that are covered by your plan that are often excluded from Part D Prescription Drug Plans. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.</p>	
<p>Benzodiazepines and Barbiturates Cosmetics Cough and Cold DESI Over the Counter Vitamins and Minerals</p>	<p>See Formulary for complete list of drugs covered</p>
<ul style="list-style-type: none"> • Generics 	<p>You pay your retail or mail order generic copay</p>
<ul style="list-style-type: none"> • Brands 	<p>You pay your retail or mail order brand copay</p>
<p>Non Part D Diabetic Supplies</p>	<p>Lancets Urine Test Strips Blood Sugar Diagnostics and Glucometers</p>
<ul style="list-style-type: none"> • Generics 	<p>\$0 copay</p>
<ul style="list-style-type: none"> • Brands 	<p>\$0 copay</p>
<p>Contraceptive Devices</p>	<p>Limited to one (1) per year</p>
<ul style="list-style-type: none"> • “Prescription” 	<p>\$0 copay</p>

- When a member’s physician has specified “dispense as written” (DAW) for non-preferred brand name drugs or non-formulary drugs, the copay for preferred brand name formulary drugs will apply.
When a member’s physician has not specified DAW for non-preferred brand name drugs or non-formulary drugs, the Tier 3 copay will apply.
- Your plan includes coverage for smoking cessation drugs prescribed by a physician.

- **Retail Pharmacy Supply Limits (participating and non-participating)** – 30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but, require a double copay (available only at retail pharmacies).
- **Outpatient Specialty Medications** – Outpatient specialty medications must be dispensed by CuraScript.
Specialty medications are not limited to a 30-day supply.
- **Annual Out of Pocket** – Member copays for drugs covered under “Extra Covered Drug Groups” do not apply towards satisfaction of your annual out of pocket maximum. Additionally, these drugs do not qualify for 100% coverage after you meet your annual out of pocket maximum.
- **Coverage Gap Discount Program:** If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2012, you will receive this discount once the costs paid by you and this plan reaches \$2,930 and continue to receive this discount until the cost paid by you and the Coverage Gap Discount Program reaches \$4,700. Drug Manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. Your plan covers some brand drugs beyond those covered by Medicare. The discount will not apply to benefits described in the “Extra Covered Drugs” section of this Benefit Chart.

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	Tells you how to get in touch with your plan and gives you information about other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
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1. Getting started as a member

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1.

Getting started as a member

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Section

1. Introduction

1.1 You are enrolled in Anthem Blue Cross MedicareRx (PDP), which is a Medicare Prescription Drug Plan

You are covered by Original Medicare or another plan's Medicare Advantage plan for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, Anthem Blue Cross MedicareRx (PDP).

There are different types of Medicare plans. Anthem Blue Cross MedicareRx (PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

1.2 What is the Evidence of Coverage booklet about?

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

This plan is offered by Anthem Blue Cross. (When this Evidence of Coverage says as “we,” “us,” or “our,” it means Anthem Blue Cross. When it says “plan” or “your plan,” it means Anthem Blue Cross MedicareRx (PDP).)

The words “coverage” and “covered drugs” refer to the prescription drug coverage available to you as a member of Anthem Blue Cross MedicareRx (PDP).

1.3 What does this Chapter tell you?

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

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

1.4 What if you are new to your plan?

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

If you are confused or concerned or just have a question, please contact your plan's Customer Service (**phone numbers are listed on the front cover of this booklet**).

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1.5 **Legal information about the Evidence of Coverage**

It's part of our contract with you

This Evidence of Coverage is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The benefits described in this Evidence of Coverage are in effect during the months listed on the first page, as long as you are a validly enrolled member in this plan.

Medicare must approve our plan each year

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

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

2.1 Your eligibility requirements

You are eligible for membership in your plan as long as:

- You are eligible for coverage under your (or your spouse's) former employer's group health plan retiree benefits. If you have questions regarding your eligibility for coverage under your (or your spouse's) former employer's retiree benefits, please contact the employer's benefit administrator.
- You live in the service area in which we can provide retired group members access to network pharmacies which includes all 50 United States, the District of Columbia, and Puerto Rico and you are entitled to Medicare Part A or you are enrolled in Medicare Part B (or you have both Part A and Part B).

2.2 What are Medicare Part A and Medicare Part B?

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

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services and certain items (such as durable medical equipment and supplies).

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2.3 Here is the service area for your plan

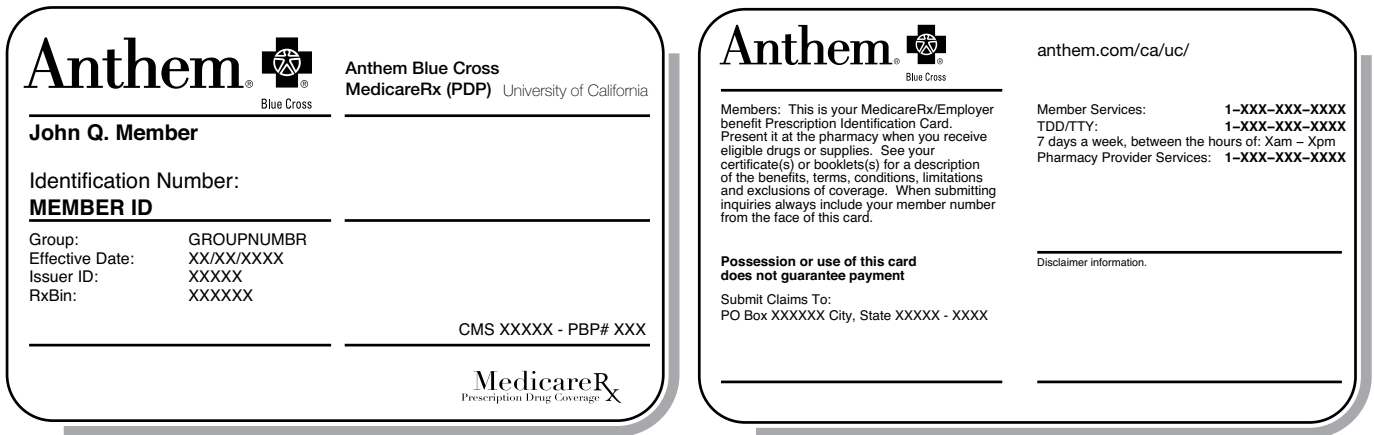
Although Medicare is a Federal program, your plan is available only to individuals who live in the service area. To remain a member of your employer/union sponsored plan, you must keep living in one of the 50 United States, or the District of Columbia and Puerto Rico, which is our Medicare defined service area. We can not service retirees or their dependents if they live outside the United States.

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

3. What other materials will you get from us?

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

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



Sample Membership Card (Front and Back)

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

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

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

What are “network pharmacies”?

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

Why do you need to know about network pharmacies?

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

If you don't have the Pharmacy Directory, you can get a copy from Customer Service (phone numbers are listed on the front cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network.

3.3 Your plan's List of Covered Drugs (Formulary)

Your plan has a List of Covered Drugs (Formulary). We call it the “Drug List.” It tells which Part D prescription drugs are covered by your plan. The drugs on this list are selected by us with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved this plan's Drug List.

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

We'll send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you call Customer Service (phone numbers are listed on the front cover of this booklet).

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

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

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

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gives more information about the Explanation of Benefits and how it can help you keep track of your drug coverage.

An Explanation of Benefits summary is also available upon request. To get a copy, please contact Customer Service.

4. Your monthly premium

4.1 How much is your plan premium?

Your coverage is provided through a contract with your (or your spouse's) former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

In some situations, you might qualify for help paying your plan premium

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

If you are already enrolled and getting help from one of these programs, **the information about premiums in this Evidence of Coverage may not apply to you.** We send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Service are listed on the front cover of this booklet. Or, if you are a member of a State Pharmacy Assistance Program (SPAP) and they are helping with your premium costs, please contact your SPAP to determine what help is available to you. For contact information, please refer to the state specific agency listing located in the back of this booklet.

Because you're enrolled in an employer sponsored plan, we'll credit the amount of Extra Help received to your prior employer's bill on your behalf. If your employer pays 100% of the premium for your retiree coverage, then they are entitled to keep these funds. However, if you contribute to the premium, your former employer must apply the subsidy toward the amount you contribute to this plan.

In some situations, your plan premium could include a penalty charge each month

In some situations, you may owe additional money because of your income or when you enrolled in Part D. These situations are described below.

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- Most people will pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, go to Chapter 4, Section 11 of this booklet. You can also visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may also call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.
- Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage). For these members, the late enrollment penalty is added to the plan's monthly premium. For members on employer sponsored plans this amount is usually added to the premium charged to the employer, unless you are normally billed directly by your plan.
 - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 4, Section 10 explains the late enrollment penalty.
 - If you think that you may have a late enrollment penalty, you may want to contact your (or your spouse's) former employer's benefit administrator to find out what you will have to pay towards the penalty.
 - If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

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

- Your copy of Medicare & You 2012 gives information about these premiums in the section called "2012 Medicare Costs." This explains how the Part B premium differs for people with different incomes.

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- Everyone with Medicare receives a copy of Medicare & You each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of Medicare & You 2012 from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

4.2 **Can we change your monthly plan premium during the year?**

Generally, your plan premium won't change during the benefit year chosen by your former employer. We will tell you in advance if there will be any changes for the next benefit year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered.

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

You can find out more about the Extra Help program in Chapter 2, Section 7.

5. **Please keep your plan membership record up to date**

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

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

The pharmacists in your plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)

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- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Customer Service (phone numbers are on the front cover of this booklet).

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

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

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

6. We protect the privacy of your personal health information

6.1 We make sure that your health information is protected

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

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

7. How other insurance works with our plan

7.1 Which plan pays first when you have other insurance?

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

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

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Section

Your plan contacts (how to contact us, including how to reach Customer Service at your plan)

1.

How to contact your plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to Anthem Blue Cross MedicareRx (PDP) Customer Service. We will be happy to help you.

Customer Service

Call 1-866-470-6265

8 a.m. to 9 p.m. EST, Monday through Friday.

Calls to this number are free. Customer Service also has free language interpreter services available for non-English speakers.

TTY 1-877-247-1657

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Write Anthem Blue Cross MedicareRx (PDP)

P.O. Box 110

Fond du Lac, WI 54936

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

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

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

You may call us if you have questions about our coverage decision, appeals, or complaint processes.

**Coverage Decisions, Appeals or Complaints
for Part D Prescription Drugs**

Call 1-866-470-6265

Calls to this number are free.

TTY 1-877-247-1657

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Fax 1-888-458-1407

Write Senior Appeals and Grievances

4361 Irwin Simpson Rd.
Mason, OH 45040

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

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

Payment Requests

Call 1-866-470-6265

Calls to this number are free.

TTY 1-877-247-1657

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Fax 1-888-458-1407

Write Anthem Blue Cross MedicareRx (PDP)

P.O. Box 110
Fond du Lac, WI 54936

Section

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

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Prescription Drug Plans, including us.

Medicare

Call 1-800-MEDICARE, or 1-800-633-4227

Calls to this number are free. 24 hours a day, 7 days a week

TTY 1-877-486-2048

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free.

Website www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool:** Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”
- **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Health & Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.

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If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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

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

The State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Counselors can also help you understand your Medicare plan choices and answer questions about switching plans. For contact information, please refer to the state specific agency, which is located in the SHIP section of Chapter 11 in this booklet.

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

There is a Quality Improvement Organization (QIO) for each state. The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare.

You should contact the Quality Improvement Organization if you have a complaint about the quality of care you have received. For example, you can contact the QIO if you were given the wrong medication or if you were given medications that interact in a negative way. For contact information, please refer to the state specific agency, which is located in the QIO section of Chapter 11 in this booklet.

Section

5. Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security Administration**Call 1-800-772-1213**

Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use the automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY 1-800-325-0778

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.

Website www.ssa.gov**6. Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)**

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

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

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

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To find out more about Medicaid and its programs, please refer to the state specific agency listing located in Chapter 11 of this booklet.

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

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

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

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

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

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

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

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There are programs in Puerto Rico to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (phone numbers are located in the back of this booklet). Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov for more information.

If you qualify for Extra Help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" (LIS Rider) that explains your costs as a member of this plan. If the amount of your Extra Help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" (LIS Rider).

Medicare Coverage Gap Discount Program

If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2012, you will receive this discount once the costs paid by you and this plan reaches \$2,930 and continue to receive this discount until the cost paid by you (or those paying on your behalf as defined in Section 6.2) reaches \$4,700.

Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. If your plan covers brand drugs beyond those covered by Medicare, the discount will not apply to the Extra Covered Drugs. If your plan covers drugs beyond those covered by Medicare, your benefit chart will have an "Extra Covered Drug Groups" section. Please see your benefit chart in the front of this booklet.

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

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

Section
(con't)**What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?**

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

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

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

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

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

To find out more about SPAP, please refer to the state specific agency listing located in Chapter 11 of this booklet.

8. How to contact the Railroad Retirement Board

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

Railroad Retirement Board

Call 1-877-772-5772

Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

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TTY 1-312-751-4701

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are not free.

Website www.rrb.gov

9. Do you have “group insurance” or other health insurance from another employer?

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

Using your plan's coverage for your Part D prescription drugs

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Using your plan's coverage for your Part D prescription drugs (con't)

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Section

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

The “Extra Help” program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** If you qualify for Extra Help, we will send you by mail an “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), that tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are listed on the front cover of this booklet.

1. Introduction**1.1 This chapter describes your coverage for Part D drugs**

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

In addition to your coverage for Part D drugs through your plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your Medicare & You Handbook.) Your Part D prescription drugs are covered under our plan. This chapter explains rules for using your coverage for Part D drugs under our plan. The next chapter tells what you pay for Part D drugs (Chapter 4, What you pay for your Part D prescription drugs).

Section

1.2 Basic rules for your plan's Part D drug coverage

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

- You must have a provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription. (See Section 2, Fill your prescriptions at a network pharmacy.)
- If your Plan has a Closed Formulary (Closed Drug List), you have coverage for most, but not all, Medicare Part D eligible drugs. The drugs on this list are all approved by the FDA and are selected by the Plan with the help of a team of doctors and pharmacists. Not all drugs are on the Closed Formulary. The drugs covered under your plan are listed in your Plan's Drug List. (The benefit chart in the front of this booklet will tell you if your plan has a Closed Formulary.)
- If your Plan has an Open Formulary (Open Drug List), you have coverage for all Medicare Part D eligible drugs as well as coverage for certain additional drugs not typically covered by Medicare Part D plans. The additional drugs beyond those typically covered by Medicare on this list are all approved by the FDA and are selected by the Plan with the help of a team of doctors and pharmacists. The drugs covered under your plan are listed in your Plan's Drug List or your benefit chart. (The benefit chart in the front of this booklet will tell you if your plan has an Open Formulary.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

2. Fill your prescription at a network pharmacy or through your plan's mail-order service**2.1 To have your prescription covered, use a network pharmacy**

In most cases, your prescriptions are covered only if they are filled at your plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section

2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

You can look in your Pharmacy Directory, or call Customer Service (phone numbers are listed on the front cover of this booklet) to find a network pharmacy in your area. Choose whatever is easiest for you.

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

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves your plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are listed on the front cover of this booklet) or use the Pharmacy Directory.

What if you need a specialized pharmacy?

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

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

To locate a specialized pharmacy, look in your Pharmacy Directory or call Customer Service (phone numbers are listed on the front cover of this booklet).

Section

2.3 Using your plan's mail-order services

Your plan's mail-order service requires you to order up to a 90-day supply for most drugs. Specialty drugs are only available in a 30-day supply on most plans. Please check the benefit chart located in the front of this booklet to verify the maximum day supply limits in your plan for mail-order drugs.

To get order forms and information about filling your prescriptions by mail, simply call Customer Service.

Usually a mail-order pharmacy order will get to you in no more than 14 days. Pharmacy processing time will average about two to five business days; however, you should allow additional time for postal service delivery. It is advisable for first-time users of the mail-order pharmacy to have at least a 30-day supply of medication on hand when a mail-order request is placed. If the prescription order has insufficient information, or if we need to contact the prescribing physician, delivery could take longer.

It is advisable for first-time users of the mail-order pharmacy to ask the doctor for two signed prescriptions:

- One for an initial supply to be filled at their local retail participating pharmacy.
- The second for up to a three-month supply with refills to send to the mail-order pharmacy.

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

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. You are not required to use the mail-order service to get a longer term supply of mail-order drugs. If you get a longer term supply of mail-order drugs at a retail network pharmacy, your cost-sharing may be different than it is for a longer term supply from the mail-order service. Please check the benefit chart located in the front of this booklet to find out what your costs will be if you get a longer term supply from a retail pharmacy. You can also call Customer Service for more information.

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2. For certain kinds of drugs, you can use your plan's network **mail-order services**. Your plan's mail-order service are marked as "**mail-order**" drugs in our Drug List. Our plan's mail-order service allows you to order up to a 90-day supply for most drugs. **Specialty drugs are only available in a 30-day supply on most plans. Please check the benefit chart located in the front of this booklet to verify the maximum day supply limits in your plan for mail-order drugs.** See Section 2.3 for more information about using your mail-order services.

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

Your prescription may be covered in certain situations

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

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

- You are unable to obtain a covered drug in a timely manner within our service area because a network pharmacy that provides 24-hour service is not available within a 25-mile driving distance.
- You are filling a prescription for a covered drug and that particular drug (for example, an orphan drug or other specialty pharmaceutical) is not regularly stocked at an accessible network retail or mail-order pharmacy.
- The prescription is for a medical emergency or urgent care.
- The pharmacy is not located outside the United States or its Territories.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy in the area where you are traveling within the United States.

How do you ask for reimbursement from your plan?

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

In addition to paying the copayments/coinsurances listed on the benefit chart located in the front of this booklet, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

Section

3. If you have a closed formulary plan, your drugs need to be on your plan's "Drug List"

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

Your plan has a "List of Covered Drugs (Formulary)." In this Evidence of Coverage, we call it the "Drug List."

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

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

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

Your drug list includes both brand-name and generic drugs

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

What is not on the Drug List?

The plan does not cover all prescription drugs.

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

3.2 How do "cost-sharing tiers" for drugs on the Drug List impact my cost?

Every drug on your plan's Drug List is in one of your plan's cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. The types of drugs placed into the cost-sharing tiers used by your plan are shown in the benefit chart located in the front of this booklet.

Section
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To find out which cost-sharing tier your drug is in, please check your plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is also shown in the benefit chart located in the front of this booklet.

3.3 How can you find out if a specific drug is on your drug list?

You have two ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Call Customer Service to find out if a particular drug is on your plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are listed on the front cover of this booklet.

4. There are restrictions on coverage for some drugs

4.1 Why do some drugs have restrictions?

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

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

4.2 What kinds of restrictions?

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

Section
(con't)**Using generic drugs whenever you can**

Generally, a “generic” drug works the same as a brand-name drug and usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version.** However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from us before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by your plan.

Trying a different drug first

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

Quantity limits

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

4.3 Do any of these restrictions apply to your drugs?

Your plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check your drug list. For the most up-to-date information, call Customer Service (phone numbers are listed on the front cover of this booklet).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

Section

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

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

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

- **What if the drug you want to take is not covered by your plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by your plan have extra rules to restrict their use. For example, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be?** Your plan puts each covered drug into one cost-sharing tier. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

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

5.2 What can you do if your drug is restricted in some way?

If coverage for your drug is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

Section
(con't)**You may be able to get a temporary supply**

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

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

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

- If you are on a Closed Formulary plan, the drug you have been taking is **no longer on your plan's Drug List**.
- Or for all plans, the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

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

- **For those members who were in this plan last year and aren't in a long-term care facility:**

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

- **For those members who are new to this plan and aren't in a long-term care facility:**

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

- **For those members who are new to the plan and reside in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in this plan. The first supply will be for a maximum of 91 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in this plan.

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

We will cover one 91-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

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

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(con't)

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

You can change to another drug

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

You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

You can change to another drug

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

You can ask for an exception

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

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(con't)

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

6.1 The Drug List can change during the year

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

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

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

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

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

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

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

Do changes to your drug coverage affect you right away?

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

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.

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- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

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

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

- If a **brand-name drug you are taking is replaced by a new generic drug**, we must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
 - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, we will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your provider will also know about this change and can work with you to find another drug for your condition.

7. What types of drugs are *not* covered by your plan?

7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself or they may be covered under your medical plan.

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

- Your plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Your plan cannot cover a drug purchased outside the United States and its territories.
- Your plan usually cannot cover off-label use. "Off-label use" is any use of the

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drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

- Generally, coverage for "off-label use" is allowed. Medicare sometimes allows us to cover "off-label uses" of a prescription drug. Coverage is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then your plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans unless your plan covers them as 'Extra Covered Drug Groups'. Please see the 'Extra Covered Drug Groups' section of the benefit chart located in the front of this booklet to find out which of the drugs listed below are covered under your plan.

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

If you have coverage for some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage), shown in the "Extra Covered Drug Groups" section of the benefit chart located in the front of this booklet, the amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.)

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help will not pay for the drugs not normally covered. (Please refer to your formulary or call Customer Service for more information.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription

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drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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

8.1 Show your membership card

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

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

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then ask us to reimburse you for our share. See Chapter 5, Section 2.1 for information about how to ask your plan for reimbursement.)

9. Part D drug coverage in special situations

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

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, your Part D plan will cover your drugs as long as the drugs meet all rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, your Part D plan will cover your drugs as long as the drugs meet all rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

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Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 8, Ending your membership in your plan, tells when you can leave your plan and join a different Medicare plan.)

9.2 What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your Pharmacy Directory to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service.

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

If you need a drug that is not on your Drug List or is restricted in some way, we will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 91 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in your plan.

If you have been a member of your plan for more than 90 days and need a drug that is not on your Drug List or if your plan has any restriction on the drug's coverage, we will cover one 34-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by your plan that might work just as well for you. Or you and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

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

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

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Some drugs may be covered under Medicare Part B in some situations and through your Part D plan in other situations. But drugs are never covered by both Part B and your Part D plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or your Part D plan for the drug.

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

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

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

9.5 What if you’re also getting drug coverage from another group plan?

Do you currently have other prescription drug coverage through your (or your spouse’s) employer or retiree group? If so, please contact **that group’s benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with this plan.

10. Programs on drug safety and managing medications

10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

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

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

10.2 **Programs to help members manage their medications**

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are on the front cover of this booklet).

What you pay for your Part D prescription drugs

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Section

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

The “Extra Help” program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** You will be mailed the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this rider, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are listed on the front cover of this booklet.

1. Introduction**1.1 Use this chapter together with other materials that explain your drug coverage**

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered by your plan. To find out which Extra Covered Drug Groups are covered by your plan, please look at the benefit chart located in the front of this booklet.

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

- **Your plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.
 - It also tells which of the “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of your drug list, call Customer Service (phone numbers are listed on the front cover of this booklet).

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- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by your plan.
- **Your plan's Pharmacy Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The Pharmacy Directory has a list of pharmacies in your plan's network and it tells how you can use your plan's mail-order service. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month's supply).

2. We send you reports that explain payments for your drugs and which coverage stage you are in

2.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB")

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

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

Your plan will prepare a written report called the Explanation of Benefits (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what your plan paid, and what you and others on your behalf paid.
- **Totals for the benefit year used by your group plan (see dates on the first page of this booklet).** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

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2.2 Help us keep our information about your drug payments up to date

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask your plan to pay its share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of your plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an Explanation of Benefits (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are listed on the front cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

Section

3. During the Initial Coverage Stage, your plan pays its share of your drug costs and you pay your share

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

During the Initial Coverage Stage, your plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

Your plan has Cost-Sharing Tiers

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

To find out what copayment or coinsurance you will pay for drugs in each cost-sharing tier, please see the benefit chart located in the front of this booklet.

To find out which cost-sharing tier your drug is in, please check your plan's Drug List.

Your pharmacy choices

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

- A retail pharmacy that is in your plan's network
- A pharmacy that is not in your plan's network
- Your plan's mail-order pharmacy

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

3.2 When does the Initial Coverage Stage end?

If your plan provides the same Initial Coverage until you reach your True Out of Pocket amount, the benefit chart located in the front of this booklet will not show an Initial Coverage Limit amount. The benefit chart will only show the True Out of Pocket amount.

If your plan provides different coverage once the Initial Coverage limit is reached, the benefit chart located in the front of this booklet will show the Initial Coverage Limit amount.

If your plan includes an Initial Coverage Limit, your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

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- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the benefit year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What your plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

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

3.3 **How Medicare calculates your out-of-pocket costs for prescription drugs**

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$2,930, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

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

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Initial Coverage Stage.
 - The Coverage Gap Stage (if your plan has this stage).
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When the amount you (or those paying on your behalf) have paid for covered drugs reaches the True Out of Pocket (TrOOP) amount shown in the benefit chart located in the front of this booklet, you will move to the Catastrophic Coverage Stage.

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

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

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

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are on the front cover of this booklet).

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

- **We will help you.** The Explanation of Benefits (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report).
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

4. Your cost for covered Part D drugs may change once the amount you and the plan pays reaches \$2,930

4.1 You can look at the benefit chart located in the front of this booklet to find out if your copay or coinsurance changes once you and the plan have paid \$2,930 for covered Part D drugs

If your copay or coinsurance amount does not change until you reach your True Out of Pocket amount, the benefit chart located in the front of this booklet will not have a “Gap Coverage” section.

If your copay or coinsurance amount does change once you reach the \$2,930 Initial Coverage Limit, the benefit chart located in the front of this booklet will include a “Gap Coverage” section that shows what you must pay during the Gap Coverage Stage.

If you are not receiving help to pay your share of drug cost through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2012, you will receive this discount once the costs paid by you and this plan reaches \$2,930 and continue to receive this discount until the cost paid by you (or those paying on your behalf as defined in Section 6.2) reaches \$4,700.

Drug Manufacturers have agreed to provide this discount on brand drugs which Medicare considers Part D qualified drugs. Your plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to benefits described in the “Extra Covered Drugs” section of the benefit chart located in the front of this booklet.

Once your total out-of-pocket costs reach the amount shown on the benefit chart located in the front of this booklet, you will qualify for catastrophic coverage.

Section

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

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

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

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

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Initial Coverage Stage.
 - The Coverage Gap Stage (if your plan has this stage).
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare’s “Extra Help” Program are also included.
- Payments made by the Medicare Coverage Gap Discount Program are also included.

Moving on to the Catastrophic Coverage Stage:

When the amount you (or those paying on your behalf) have paid for covered drugs reaches the True Out of Pocket (TrOOP) amount shown in the benefit chart located in the front of this booklet, you will move to the Catastrophic Coverage Stage

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

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

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

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell us. Call Customer Service to let us know (phone numbers are listed on the front cover of this booklet).

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

- **We will help you.** The Explanation of Benefits (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report).
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

Section

5. During the Catastrophic Coverage Stage, your plan pays most of the cost for your drugs

5.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the benefit year

You qualify for the Catastrophic Coverage Stage when you have reached your out-of-pocket limit for the benefit year. Once you are in the Catastrophic Coverage Stage, you will stay in this coverage stage until the end of the benefit year selected by your (or your spouse's) former employer.

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

You can find your cost-sharing amounts in the Catastrophic Coverage section of the benefit chart located in the front of this booklet.

6. Additional benefits information

6.1 Your plan offers additional benefits

We provide additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your Initial Coverage Stage or your out-of-pocket costs. You can find the additional types of drugs covered by your plan in the “Extra Covered Drug Groups” section of the benefit chart located in the front of this booklet. You can find out which specific drugs are covered by checking your “Drug List”.

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

7.1 Your plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Your plan provides coverage for a number of Part D vaccines. There are two parts to your coverage of vaccinations:

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

Section
(con't)**What do you pay for a Part D vaccination?**

What you pay for a Part D vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered Part D drugs. You can find these vaccines listed in your plan's List of Covered Drugs (Formulary).
 - Other vaccines are considered medical benefits. They are covered under Original Medicare.
- 2. Where you get the vaccine medication.**
- 3. Who gives you the vaccination shot.**

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

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

To show how this works, here are three common ways you might get a Part D vaccination shot. If you have a Coverage Gap Stage, you are responsible for all of the costs associated with vaccines (including their administration) during these coverage stages of your benefit.

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

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

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask your plan to pay its share of the cost by using the procedures that are described in Chapter 5 of this booklet (Asking us plan to pay our share of the costs for covered drugs).
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

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- Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.
- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
 - When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask your plan to pay its share of the cost by using the procedures described in Chapter 5 of this booklet.
 - You will be reimbursed the amount charged by the doctor less the amount for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Please note that Part B covers the vaccine and administration for influenza, pneumonia and Hepatitis B injections.

When billing us for a vaccine, please include a bill from the provider with the date of service, the NDC code, the vaccine name and the amount charged. Send the bill to:

Anthem Blue Cross MedicareRx (PDP)

Pharmacy Claims

P.O. Box 66752

St Louis, MO 63166-6752

We can help you understand the costs associated with vaccines (including administration) available under this plan, especially before you go to your doctor. For more information, please contact Customer Service (phone numbers are listed on the front cover of this booklet).

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

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

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

Section

8. Do you have to pay the Part D “late enrollment penalty”?

8.1 What is the Part D “late enrollment penalty”?

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

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

Your late enrollment penalty is considered to be part of your plan premium.

The penalty is added to the monthly premium charged to your (or your spouse’s) former employer for your coverage. If you think you may have a late enrollment penalty, you should contact your (or your spouse’s) former employer to see what amount you will have to pay.

8.2 How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn’t have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2011, this average premium amount was \$32.34. This amount may change for 2012.
- To get your monthly penalty, you multiply the penalty percentage and round it to the nearest 10 cents. In the example here it would be 14% times \$32.34, which equals 4.53. This rounds to \$4.50. This amount would be added **to the monthly premium for someone with a late enrollment penalty.**

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

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

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

8.3 **In some situations, you can enroll late and not have to pay the penalty**

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

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage.**" Please note:
 - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
 - If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

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- The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, please look in your Medicare & You 2012 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

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

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

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

9. Do you have to pay an extra Part D amount because of your income?

9.1 Who pays an extra Part D amount because of income?

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

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

Section

9.2 How much is the extra Part D amount?

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

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

If you filed an individual tax return and your income in 2010 was:	If you were married but filed a separate tax return and your income in 2010 was:	If you filed a joint tax return and your income in 2010 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium):
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	Your plan premium
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$11.60 + Your plan premium
Greater than \$107,000 and less than or equal to \$160,000		Greater than \$214,000 and less than or equal to \$320,000	\$29.90 + Your plan premium
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.10 + Your plan premium
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$66.40 + Your plan premium

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

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

Asking your plan to pay its share of the costs for covered drugs

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Section

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

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

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask your plan to pay you back (paying you back is often called “reimbursing” you).

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

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Sec. 2.5 to learn more.)

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

2. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call your plan to get your member information, but there may be times when you may need to pay if you do not have your card.

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

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on your plan's List of Covered Drugs (Formulary); or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

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

4. If you are retroactively enrolled in our plan

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

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

- Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has information about how to make an appeal.

2. How to ask your plan to pay you back

2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.

Please contact Customer Service and ask for the form. See Chapter 2 for information about how to contact Customer Service.

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

ESI

P.O. Box 66752

St. Louis, MO 63166-6752

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

Section

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

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

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

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of all but your share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the drug is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. These are examples of situations in which you may need to ask your plan to pay you back:

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

For the details on how to make this appeal, go to Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

Section

Other situations in which you should save your receipts and send copies to us

4.

4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

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

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

1. When you buy the drug for a price that is lower than our price

If your plan includes stages in which you are responsible for 100% of the drug costs, sometimes you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on your Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in a Part D plan stage in which you are responsible for 100% of the drug costs, your Part D plan will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

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

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

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

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

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Section

Your plan must honor your rights as a member of the plan

1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats)

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

Your plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about your plan's benefits that is accessible and appropriate for you.

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

1.2 We must treat you with fairness and respect at all times

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. For contact information, please refer to the state specific agency listing located in the back of this booklet.

If you have a disability and need help with access to care, please call Customer Service (phone numbers are listed on the front cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

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

As a member of this plan, you also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting

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your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

1.4 We must protect the privacy of your personal health information

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

- Your “personal health information” includes the personal information you gave us when you enrolled in your plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of your plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

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

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

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If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are listed on the front cover of this booklet).

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Notice Effective April 1, 2010

State Notice of Privacy Practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request.

Please call the phone number printed on your ID card.

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HIPAA Notice of Privacy Practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can

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also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

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How We Protect Information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card.

Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Section
(con't)**Breast reconstruction surgery benefits**

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing copayments and/or coinsurance. Contact your Plan Administrator for more information.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following companies:

Anthem Blue Cross.

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

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

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

- **Information about your plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
 - For example, you have the right to get information from us about the pharmacies in our network.
 - For a list of the pharmacies in your plan's network, see the Pharmacy Directory.
 - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are listed on the front cover of this booklet).

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- **Information about your coverage and rules you must follow in using your coverage.**
 - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are listed on the front cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation, even if you received the drug from an out-of-network pharmacy.
 - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask your plan to pay its share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

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

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

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

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

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the appropriate state-specific agency (such as the State Department of Health). For contact information, please refer to the state-specific agency listing located in the back of this booklet.

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow-up on a problem or concern depends on the situation. You might need to ask your plan to make a coverage decision for you, make an appeal to us to change a coverage decision or make a complaint. Whatever you do – ask for a coverage decision, make an appeal or make a complaint – **we are required to treat you fairly.**

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You have the right to get a summary of information about the appeals and complaints that other members have filed against your plan in the past. To get this information, please call Customer Service (phone numbers are listed on the front cover of this booklet).

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

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

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights. For contact information, please refer to the state specific agency listing located in the back of this booklet.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are listed on the front cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization, go to Chapter 2, Section 3. For contact information, please refer to the state specific agency listing located in the back of this booklet.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1.9 **How to get more information about your rights**

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

- You can **call Customer Service** (phone numbers are listed on the front cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization, go to Chapter 2, Section 3. For contact information, please refer to the state specific agency listing located in the back of this booklet.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section

You have some responsibilities as a member of this plan

2.1 What are your responsibilities?

Things you need to do as a member of this plan are listed below. If you have any questions, please call Customer Service (phone numbers are listed on the front cover of this booklet). We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
 - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are listed on the front cover of this booklet).
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called “**coordination of benefits**” because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and pharmacist that you are enrolled in this plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

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- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums, if any, to your (or your spouse's) or former employer or union (or, if you are billed directly, you must send your payment to the address listed on your billing statement), to continue being a member of your plan.
 - For most of your drugs covered by your plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). You can find this information listed on the benefit chart located in the front of this booklet.
 - If you get any drugs that are not covered by your plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- **Tell us if you move.** If you're going to move, it's important to tell us right away. Call Customer Service (phone numbers are listed on the front cover of this booklet).
 - **If you move outside of the plan service area, you cannot remain a member of the plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you're moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - **If you move within the service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving your plan.
 - Phone numbers and calling hours for Customer Service are listed on the front cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

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

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Chapter
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2012 Evidence of Coverage for Anthem Blue Cross MedicareRx (PDP)

**What to do if you have a problem or complaint
(coverage decisions, appeals, complaints) (con't)**

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BACKGROUND

1. Introduction

1.1 What to do if you have a problem or concern

Please call us first

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

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

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

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

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

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

1.2 What about the legal terms?

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

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

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

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

2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. For contact information, please refer to the state specific agency listing located in the back of this booklet.

You can also get help and information from Medicare

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

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

Section

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

3.

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

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

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

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

<p>YES.</p> <p>My problem is about benefits or coverage.</p> <p>Go on to the next section of this chapter, Section 4: "A guide to the basics of coverage decisions and making appeals"</p>	<p>No.</p> <p>My problem is <u>not</u> about benefits or coverage.</p> <p>Skip ahead to Section 7 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service or other concerns."</p>
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COVERAGE DECISIONS AND APPEALS

A guide to the basics of coverage decisions and appeals

4.

4.1 Asking for coverage decisions and making appeals: the big picture

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The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

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

Making an appeal

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

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

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to your plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

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

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

- You **can call Customer Service** (phone numbers are listed on the front cover of this booklet).
- To **get free help from an independent organization** that is not connected with your plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter). For contact information, please refer to the state specific agency listing located in the back of this booklet.

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- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Service and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give your plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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



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

.....

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

Your benefits as a member of this plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in your plan’s List of Covered Drugs (Formulary) and the use of the the drug is a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

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

Part D coverage decisions and appeals

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

Legal Terms An initial coverage decision about your Part D drugs is called a “**coverage determination.**”

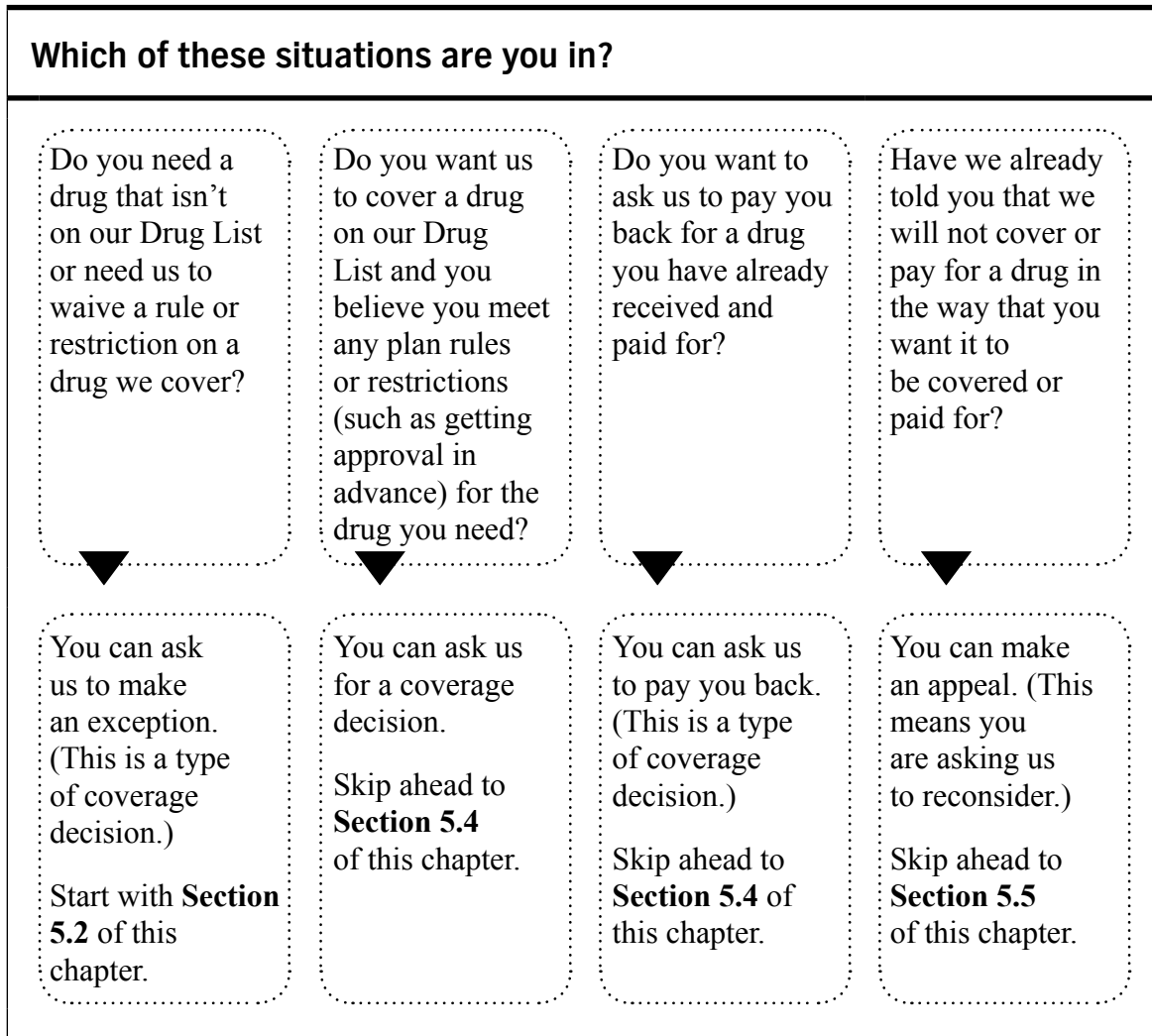
Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on your plan’s List of Covered Drugs (Formulary)
 - Asking us to waive a restriction on your plan’s coverage for a drug (such as limits on the amount of the drug you can get)
 - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on your plan’s List of Covered Drugs (Formulary) but we require you to get approval from us before we will cover it for you.)
 - **Please note:** If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

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



5.2 What is an exception?

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

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

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

.....

Legal Terms Asking for coverage of a drug that is not on your drug list is sometimes called asking for a **"formulary exception."**

.....

- If we agree to make an exception and cover a drug that is not on your drug list, you will need to pay the cost-sharing amount that applies to all of our drugs OR drugs for the non-preferred brand tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 3.)

2. Removing a restriction on the plan's coverage for a covered drug.

There are extra rules or restrictions that apply to certain drugs on your plan's List of Covered Drugs (Formulary) (for more information, go to Chapter 3).

.....

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

.....

- The extra rules and restrictions on coverage for certain drugs include:
 - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
 - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
 - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If your plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

Section
(con't)**3. Changing coverage of a drug to a lower cost-sharing tier.**

Every drug on your plan's Drug List is in one of the cost-sharing tiers. The cost-sharing tiers used in your plan are shown in the benefit chart located in the front of this booklet. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

**Legal
Terms**

Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **“tiering exception.”**

- If your drug is in the non-preferred brand tier you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred brand tier. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in the Specialty Drug tier.

5.3 Important things to know about asking for exceptions**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, your Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the benefit year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

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

Section

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

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

What to do

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

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

.....
Legal A “fast decision” is called an “**expedited coverage**
Terms **determination.**”
.....

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- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision only if you are asking for a **drug you have not yet received**. (You can’t get a fast decision if you are asking us to pay you back for a drug you are already bought.)
 - You can get a fast decision **only** if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition doesn’t meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

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

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we’ll give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we don’t meet this deadline, we’re required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we’ll explain this review organization and explain what happens at Appeal Level 2.

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

Deadlines for a **"standard"** coverage decision about a drug you have not yet received

- If we're using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested** –
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- If our answer is no to **part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a **"standard"** coverage decision about payment for a drug you have already purchased:

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
 - **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.

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- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If your plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

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

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

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

What to do

- **To start your appeal, you, your doctor, or your representative must contact us.**
 - For details on how to reach us by phone, fax or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, How to contact us when you are asking for a coverage decision, appeal, or complaint about your Part D prescription drugs.
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact our plan when you are making an appeal about your part D prescription drugs).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

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- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

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

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

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

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Section
(con't)**Deadlines for a “standard” appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
 - If we don’t give you a decision within 7 calendar days, we’re required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

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

5.6 Step-by-step: How to make a Level 2 Appeal

If your plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision your plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

**Legal
Terms**

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

Section
(con't)**Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.**

- If your plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

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

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with your plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with your plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.

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- **If the Independent Review Organization says yes to part or all of what you requested –**
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

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

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

6. Taking your appeal to Level 3 and beyond

6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

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

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum

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level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal

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

- **If the Administrative Law Judge says yes to your appeal, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge says no to your appeal, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal

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

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to

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your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

7. How to make a complaint about quality of care, waiting times, customer service, or other concerns



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

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

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can “make a complaint”

Quality of your medical care

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

Respecting your privacy

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

Disrespect, poor customer service, or other negative behaviors

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

Waiting times

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

Cleanliness

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

Information you get from us

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

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

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

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

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

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

7.2 The formal name for “making a complaint” is “filing a grievance”**Legal
Terms**

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

Section

7.3 Step-by-step: Making a complaint

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

Usually, calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know. See Chapter 2 for information about how to contact Customer Service.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- You or someone you name may file a grievance. The person you name would be your “representative.” You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the court or in accordance with state law to act for you.
- If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service (phone numbers are listed on the front cover of this booklet).
- A grievance must be filed either verbally or in writing within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.

Whether you call or write, you should contact Customer Service right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about.

If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint. If you have a “fast” complaint, it means we will give you an **answer within 24 hours.**

.....
Legal Terms What this section calls a “fast complaint” is also called an “expedited grievance.”
.....

Section
(con't)**Step 2: We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
- To find the name, address and phone number of the Quality Improvement Organization for your state, please refer to the state specific agency listing located in the back of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to your plan and also to the Quality Improvement Organization.

8.**Ending your membership in your plan**

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Section

1. Introduction

1.1 This chapter focuses on ending your membership in your plan

Ending your membership in your plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

2. When can you end your membership in your plan?

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

2.1 You can end your membership during the Annual Enrollment Period for Individual (non-group) Plans

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

- **When is the Annual Enrollment Period for Individual (non-group) Plans?**
The AEP that occurs in 2011 and beyond is from October 15 through December 7 of every year. It is also referred to as the “Fall Open Enrollment” season in Medicare beneficiary publications and other tools.

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- **What type of plan can you switch to during the Annual Enrollment Period for Individual (non-group) Plans?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - An Individual (non-group) Medicare prescription drug plan.
 - Original Medicare *without* a separate Medicare prescription drug plan.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
 - *Or,* An Individual (non-group) Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
 - **Ending your employer sponsored Medicare Part D plan may impact your eligibility for other coverage sponsored by your employer or mean that you will not be able to re-enroll in the employer plan in the future. Before ending your employer sponsored Medicare Part D coverage, please contact your (or your spouse's) former employer.**

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

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

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

Employer or union sponsored plans may allow changes to their retiree’s enrollment at:

- The Employer’s open enrollment period, this may be any time of the year and does not have to coincide with the individual open enrollment period
- **Please check with your (or your spouse’s) former employer for additional enrollment and disenrollment options, and the impact of any changes to your employer sponsored retiree benefits**

In certain situations, members of this employer or union sponsored Part D plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

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- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact us, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - If you have permanently moved outside of the United States
 - If you have Medicaid.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service (phone numbers are on the front cover of this booklet).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - An Individual (non-group) Medicare prescription drug plan.
 - Original Medicare without a separate Medicare prescription drug plan.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- – *or* – An Individual (non-group) Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
 - **Ending your employer sponsored Medicare Part D plan may impact your eligibility for other coverage sponsored by your employer or mean that you will not be able to re-enroll in the employer plan in the future. Before ending your employer sponsored Medicare Part D coverage, please contact your (or your spouse's) former employer.**

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

- **When will your employer or union Part D plan membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

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

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

- First contact your (or your spouse’s) former employer’s group benefit administrator to get information on options available to you.
- You can **call Customer Service** (phone numbers are listed on the front cover of this booklet).
- You can find the information in the **Medicare & You 2012 Handbook**.
 - Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

3. How do you end your membership in your employer or union sponsored Part D plan?

3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in your employer or union sponsored Part D plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, there are two situations in which you will need to end your membership in a different way:

If you want to switch from your employer or union sponsored Part D plan to Original Medicare *without* a Medicare prescription drug plan, you must contact Customer Service (phone numbers are listed on the front cover of this booklet) and ask to be disenrolled from your plan.

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

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

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

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

If you would like to switch from your plan to:	This is what you should do:
<p>An Individual (non-group) Medicare prescription drug plan.</p>	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. <p>You will automatically be disenrolled from your employer or union sponsored plan when your Individual plan’s coverage begins.</p>
<p>An Individual (non-group) Medicare health plan.</p>	<ul style="list-style-type: none"> • Enroll in the Medicare plan. <p>With most Medicare health plans, you will automatically be disenrolled from your employer or union sponsored plan when your Individual plan’s coverage begins.</p> <p>If you want to leave your plan, you must <i>either</i> enroll in another Medicare prescription drug plan <i>or</i> contact Customer Service (phone numbers are listed on the front cover of this booklet) or Medicare and ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact Customer Service if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).</p>

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If you would like to switch from your plan to:	This is what you should do:
<p>Original Medicare <i>without</i> a separate Medicare prescription drug plan.</p> <p>Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 4, Section 10 for more information about the late enrollment penalty.</p>	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are on the front cover of this booklet). • You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

Until your membership ends, you must keep getting your drugs through your employer or union sponsored Part D plan

4.

4.1 Until your membership ends, you are still a member of your employer or union sponsored Part D plan

If you leave your employer or union sponsored Part D plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through this plan.

- **You should continue to use network pharmacies to get your prescriptions filled until your membership in your plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

Section

We must end your membership in your plan in certain situations

5.1 When must we end your membership in your plan?

We must end your membership in your plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move outside the United States.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in this plan and that information affects your eligibility for this plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of this plan.
 - We cannot make you leave your plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If your former employer notifies us that the employer is canceling the group contract for this plan.
- If the premiums for this plan are not paid in a timely manner.

Where can you get more information?

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

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

5.2 We cannot ask you to leave your plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave your plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section

5.3 You have the right to make a complaint if we end your membership in your plan

If we end your membership in your plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

9. Legal notices

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2.	Notice about nondiscrimination	115
3.	Additional legal notices	115

Section

1. Notice about governing law

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

2. Notice about nondiscrimination

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

3. Additional legal notices

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Assignment

The benefits provided under this Evidence of Coverage are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

Notice of claim

In the event that a service is rendered for which you are billed, you have at least 15 months to submit such claims to your plan.

You may have as long as 27 months to submit a claim depending on when the service is rendered.

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The following table explains the time frames for submitting claims.

For services you receive between:	Your claim must be submitted by:
October 1, 2010 & September 30, 2011	December 31, 2012
October 1, 2011 & September 30, 2012	December 31, 2013
October 1, 2012 & September 30, 2013	December 31, 2014

You may submit such claims to:

Anthem Blue Cross MedicareRx (PDP)

P.O. Box 110

Fond du Lac, WI 54936

Entire contract

This Evidence of Coverage and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

Waiver by agents

No agent or other person, except an executive officer of your plan, has authority to waive any conditions or restrictions of this Evidence of Coverage or the medical benefit chart located in the front of this booklet.

No change in this Evidence of Coverage shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

Refusal to accept treatment

You may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by your primary care physician. Although such refusal is your right, in some situations it may be regarded as a barrier to the continuance of the provider/patient relationship or to the rendering of the appropriate standard of care.

When a member refuses a recommended, necessary treatment or procedure and the primary care physician believes that no professionally acceptable alternative exists, the member will be advised of this belief.

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In the event you discharge yourself from a facility against medical advice, your plan will pay for covered services rendered up to the day of self-discharge. Fees pertaining to that admission will be paid on a per diem basis or appropriate Diagnostic Related Grouping (DRG), whichever is applicable.

Limitation of actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than 3 years after the service upon which the legal action is based was provided.

Circumstances beyond plan control

If there is an epidemic, catastrophe, general emergency or other circumstance beyond the company's control, neither your plan nor any provider shall have any liability or obligation except the following, as a result of reasonable delay in providing services:

- Because of the occurrence, you may have to obtain covered services from a non-network provider instead of a network provider. Your plan will reimburse you up to the amount that would have been covered under this Evidence of Coverage.
- Your plan may require written statements from you and the medical personnel who attended you confirming your illness or injury and the necessity for the treatment you received.

Plan's sole discretion

The plan may, at its sole discretion, cover services and supplies not specifically covered by the Evidence of Coverage.

This applies if the plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans.
- Information on the procedures your plan uses to control utilization of services and expenditures.
- Information on the financial condition of the company.
- General coverage and comparative plan information.

To obtain this information, call Customer Service (the phone number and hours of availability are located on the front of this booklet). The plan will send this information to you within 30 days of your request.

Section
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Information about advance directives

(Information about using a legal form such as a “living will” or “power of attorney” to give directions in advance about your health care in case you become unable to make your own health care decisions)

You have the right to make your own health care decisions. *But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?*

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would want and not want if you were not able to make decisions for yourself.
- You might want to do both – to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an “advance directive,” because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called “living will” and “power of attorney for health care” are examples of advance directives.

It’s your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance?

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 11 of this booklet tells how to contact your SHIP. (SHIPs have different names depending on which state you are in.)

Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and

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keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't.

You may want to give copies to close friends or family members as well. If you know ahead of time that you are going to be hospitalized, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, you may file a complaint with your state Department of Health.

Continuity and coordination of care

Your plan has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, your plan helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

Definitions of important words

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

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

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have paid your True Out of Pocket cost for covered drugs during the covered year. You can find this amount listed on the benefit chart located in the front of this booklet.

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

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

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

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

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by your plan and the amount, if any,

(con't) you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription is not covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

Creditable Prescription Drug

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

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

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

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

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

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

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

(con't)

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

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

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

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

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

Initial Coverage Stage – This is the stage before your total drug expenses have reached your initial coverage limit, including amounts you’ve paid and what we have paid on your behalf. To find out if your plan includes an initial coverage limit, refer to the benefit chart located in the front of this booklet.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you’re eligible

for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without “creditable” prescription drug coverage.

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

Low Income Subsidy –
See “Extra Help.”

Medicaid (or Medical Assistance)
– A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered

(con't) if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with

Prescription Drug Coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount

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

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

Medicare Prescription Drug Coverage (Medicare Part D)

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

“Medigap” (Medicare Supplement Insurance) Policy

– Medicare supplement insurance sold by private insurance companies to fill “gaps” in

(con't)

Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Multi Source Drug – A prescription drug that is manufactured and sold by more than one pharmaceutical company. Multi source drugs include both brand and generic drug options.

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

Non-Preferred Brand Drug – While these drugs meet your Part D plans safety requirements, a committee of independent practicing doctors and pharmacists which recommends drugs for our drug list did not determine that these drugs provided the same overall value that preferred brand drugs can offer. If your plan covers both preferred and non-preferred brand drugs, the non-preferred brand drugs usually cost you more. If your plan does not cover non-preferred brand drugs, and your physician

feels that you should take the non-preferred brand drug, you may request an exception. Please see Chapter 3, Section 5.2 for how to request an exception.

Original Medicare (“Traditional Medicare” or “Fee-for-service”

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

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

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

(con't)

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

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

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

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

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

Preferred Brand Drug – These are brand drugs that have been identified as excellent values both clinically and

financially. Before a drug can be designated as a preferred brand drug, a committee of independent practicing doctors and pharmacists evaluates the drug to be sure it meets standards for safety, effectiveness, and cost. On most plans, selecting a preferred brand or generic drug will save you money.

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

Quality Improvement Organization

(QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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

Select Generics – A specific list of generic drugs that have been on the market long enough to have a proven track record for effectiveness and value. A complete

(con't)

list of these drugs is included in your drug list (Formulary) that accompanies this Evidence of Coverage. Some plans have reduced copayments for Select Generics. If your plan includes a reduced copayment, you can find this information listed on the benefit chart located in the front of this booklet.

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

Single Source Drug – A prescription brand drug that is manufactured and sold only by the pharmaceutical company that originally researched and developed the drug. Single source drugs are always brand drugs.

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

Specialty Drugs - The Centers for Medicare & Medicaid Services (CMS) defines specialty drugs as any drug that costs \$600 or more per unit.

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

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

11.

State organization contact information

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Section

1. State Health Insurance Assistance (SHIP)

ALABAMA

State Health Insurance Assistance Program (SHIP), Alabama Department of Senior Services

770 Washington Avenue, Suite 470
Montgomery, AL 36130

1-800-243-5463; 1-334-242-5594

TTY/TDD: 711

www.alabamaageline.gov

ALASKA

Alaska State Health Insurance Assistance Program (SHIP)

3601 C Street, Suite 310
Anchorage, AK 99503

1-800-478-6065; 1-907-269-3648

TTY/TDD: 1-907-269-3691

www.hss.state.ak.us/dsds/medicare/

ARIZONA

Arizona State Health Insurance Assistance Program

1789 W. Jefferson Street, #950a
Phoenix, AZ 85007

1-800-432-4040; 1-602-542-6575

TTY/TDD: 711

<https://www.azdes.gov/>

ARKANSAS

Senior Health Insurance Information Program (SHIIP)

1200 West Third Street
Little Rock, AR 72201

1-800-224-6330; 1-501-371-2781

TTY/TDD: 711

<http://insurance.arkansas.gov/seniors/homepage.htm>

CALIFORNIA

California Health Insurance Counseling & Advocacy Program (HICAP)

1300 National Drive, Suite 200
Sacramento, CA 95834-1992

1-800-434-0222; 1-916-928-2506

TTY/TDD: 1-800-735-2929

www.aging.ca.gov/HICAP

COLORADO

Senior Health Insurance Assistance Program (SHIP)

1560 Broadway, Suite 850
Denver, CO 80202

1-888-696-7213; 1-303-894-7455

TTY/TDD: 1-303-894-7880

www.dora.state.co.us/insurance/senior/senior.htm

CONNECTICUT

CHOICES

25 Sigourney Street, 10th Floor
Hartford, CT 6106

1-800-994-9422; 1-860-424-5301

TTY/TDD: 1-860-424-5274

www.ct.gov/agingservices

DELAWARE

ELDERinfo

841 Silver Lake Boulevard
Dover, DE 19904

1-800-336-9500; 1-302-739-6278

TTY/TDD: 711

<http://delawareinsurance.gov/departments/elder/>

Section

1. State Health Insurance Assistance (SHIP) (con't)

DISTRICT OF COLUMBIA

Health Insurance Counseling Project (HICP)

2136 Pennsylvania Avenue North West
Washington, DC 20052

1-202-739-0668; 1-202-293-4043

TTY/TDD: 1-202-973-1079

www.dcoa.dc.gov/

FLORIDA

Serving Health Insurance Needs of Elders (SHINE)

4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000

1-800-963-5337; 1-850-414-2150

TTY/TDD: 1-800-955-8771

www.floridashine.org

GEORGIA

GeorgiaCares

2 Peachtree Street NW, Suite 9-398
Atlanta, GA 30303-3142

1-800-669-8387; 1-404-657-1727

TTY/TDD: 1-404-657-1929

www.dhr.georgia.gov/

HAWAII

Sage PLUS

250 S. Hotel Street, Suite 406
Honolulu, HI 96813

1-888-875-9229; 1-808-586-0185

TTY/TDD: 1-866-810-4379

www.hawaii.gov/health/eoa/

IDAHO

Senior Health Insurance Benefits Advisors (SHIBA)

700 West State Street, 3rd Floor
Boise, ID 83702-5868

1-800-247-4422; 1-208-334-4389

TTY/TDD: 711

www.doi.idaho.gov

ILLINOIS

Senior Health Insurance Program (SHIP)

320 W Washington
Springfield, IL 62767-0001

1-800-548-9034; 1-217-782-4105

TTY/TDD: 1-217-524-4872

www.idfpr.com/

INDIANA

State Health Insurance Assistance Program

714 W 53rd Street
Anderson, IN 46204

1-800-452-4800; 1-765-608-2322

TTY/TDD: 1-866-846-0139

www.medicare.in.gov

IOWA

Senior Health Insurance Information Program

330 Maple
Des Moines, IA 50319

1-800-351-4664; 1-515-281-3059

TTY/TDD: 1-800-735-2942

www.shiip.state.ia.us

Section

1. State Health Insurance Assistance (SHIP) (con't)

KANSAS

**Senior Health Insurance Counseling
for Kansas (SHICK)**

503 S. Kansas, New England Bldg
Topeka, KS 66603

1-800-860-5260; 1-785-296-0256

TTY/TDD: 711

www.agingkansas.org

KENTUCKY

State Health Insurance Assistance Program

275 E. Main Street, 3W-F
Frankfort, KY 40621

1-877-293-7447; 1-502-564-4595

TTY/TDD: 1-888-642-1137

www.chfs.ky.gov/dail/ship.htm

LOUISIANA

**Senior Health Insurance Information
Program (SHIP)**

P.O. Box 94214
Baton Rouge, LA 70802

1-800-259-5301; 1-225-342-5352

TTY/TDD: 711

www.ldi.state.la.us

MAINE

**Maine State Health Insurance Assistance
Program (SHIP)**

11 State House Station
Augusta, ME 04333

1-877-353-3771; 1-207-287-9229

TTY/TDD: 1-800-606-0215

www.maine.gov/dhhs/oes/hiap

MARYLAND

**Senior Health Insurance Assistance
Program (SHIP)**

301 W. Preston Street, Suite 1007
Baltimore, MD 21201

1-800-243-3425; 1-410-333-7943

TTY/TDD: 1-410-767-1083

www.mdoa.state.md.us

MASSACHUSETTS

**Serving Health Information Needs of Elders
(SHINE)**

1 Ashburton Place, 5th floor
Boston, MA 02108

1-800-243-4636; 1-617-727-9368

TTY/TDD: 1-800-872-0166

www.800ageinfo.com

MICHIGAN

**MMAP Medicare/Medicaid Assistance
Program Michigan Office of Services
to the Aging**

7109 W. Saginaw Highway
Lansing, MI 48917

1-800-803-7174

TTY/TDD: 711

www.seniorresources.us/MMAP.html

MINNESOTA

**Minnesota State Health Insurance
Assistance Program/Senior LinkAge Line**

P.O. Box 64976
St. Paul, MN 55164-0976

1-800-333-2433; 1-651-431-7453

TTY/TDD: 1-800-627-3529

www.mnaging.org

Section

1. State Health Insurance Assistance (SHIP) (con't)

MISSISSIPPI

MS State Health Insurance Assistance Program (SHIP)

750 North State Street
Jackson, MS 39202

1-800-948-3090; 1-601-359-9664
TTY/TDD: 1-800-676-4154

www.mdhs.state.ms.us/aas_info.html

MISSOURI

CLAIM

200 North Keene Street
Columbia, MO 65109

1-800-390-3330; 1-573-817-8341
TTY/TDD: 711

www.missouricclaim.org

MONTANA

Montana State Health Insurance Assistance Program (SHIP)

2030 11th Ave
Helena, MT 59604-4210

1-800-551-3191; 1-406-444-7743
TTY/TDD: 1-406-444-2590

www.dphhs.mt.gov

NEBRASKA

Nebraska Senior Health Insurance Information Program (SHIIP)

941 O Street, Suite 400
Lincoln, NE 68508

1-800-234-7119; 1-402-471-6559
TTY/TDD: 1-800-833-7352

www.doi.ne.gov/shiip

NEVADA

State Health Insurance Assistance Program (SHIP)

1860 E Sahara
Las Vegas, NV 89104

1-800-307-4444; 1-702-486-3572
TTY/TDD: 711

www.nvaging.net

NEW HAMPSHIRE

NH SHIP - ServiceLink Resource Center

129 Pleasant Street, Gallen State Office Park
Concord, NH 03301-3857

1-866-634-9412; 1-603-271-4643
TTY/TDD: 1-800-735-2964

www.servicelink.org

NEW JERSEY

State Health Insurance Assistance Program (SHIP)

P.O. Box 360
Trenton, NJ 08625-0360

1-800-792-8820; 1-609-943-4669
TTY/TDD: 711

www.state.nj.us/health/senior/ship.shtml

NEW MEXICO

Benefits Counseling Program

2550 Cerrillos Road
Santa Fe, NM 87505

1-800-432-2080; 1-505-476-4710
TTY/TDD: 711

www.nmaging.state.nm.us

Section

1. State Health Insurance Assistance (SHIP) (con't)

NEW YORK

Health Insurance Information Counseling and Assistance Program (HIICAP)

2 Empire State Plaza
Albany, NY 12223-1251

1-800-701-0501; 1-518-486-2225

TTY/TDD: 711

www.aging.ny.gov

NORTH CAROLINA

Seniors' Health Insurance Information Program (SHIIP)

11 South Boylan Avenue
Raleigh, NC 27603

1-800-443-9354; 1-919-807-6901

TTY/TDD: 1-919-715-0319

<http://www.ncdoi.com/SHIIP/Default.aspx>

NORTH DAKOTA

Senior Health Insurance Counseling (SHIC)

State Capitol, 600 East Blvd., 5th Floor
Bismarck, ND 58505-0320

1-800-247-0560; 1-701-328-9610

TTY/TDD: 1-800-366-6888

www.state.nd.us/ndins/

OHIO

The Ohio Senior Health Insurance Information Program OSHIIP

50 W. Town Street, 3rd Floor
Columbus, OH 43215

1-800-686-1578; 1-614-752-0740

TTY/TDD: 1-614-644-3745

www.ohioinsurance.gov

OKLAHOMA

Senior Health Insurance Counseling Program (SHIP)

2401 N.W. 23rd, Suite 28
Oklahoma City, OK 73107

1-800-763-2828; 1-405-522-4492

TTY/TDD: 711

www.oid.state.ok.us

OREGON

Senior Health Insurance Benefits Assistance Program (SHIBA)

250 Church Street, Suite 200
Salem, OR 97309-0405

1-800-722-4134; 1-503-378-8365

TTY/TDD: 1-800-735-2900

<http://oregonshiba.org>

PENNSYLVANIA

APPRISE

555 Walnut Street, 5th Floor
Harrisburg, PA 17101

1-800-783-7067; 1-717-772-3382

TTY/TDD: 711

www.aging.state.pa.us

RHODE ISLAND

Senior Health Insurance Program (SHIP)

Hazard Building, 74 West Road
Cranston, RI 02920

1-401-462-4444; 1-401-462-0503

TTY/TDD: 1-401-462-0740

<http://adrc.ohhs.ri.gov>

Section

1. State Health Insurance Assistance (SHIP) (con't)

SOUTH CAROLINA

**(I-CARE) Insurance Counseling Assistance
and Referrals for Elders**

1301 Gervais Street, Suite 200
Columbia, SC 29201

1-800-868-9095; 1-803-734-9887

TTY/TDD: 711

www.aging.sc.gov

SOUTH DAKOTA

**Senior Health Information & Insurance
Education (SHIINE)**

615 East 4th Street
Pierre, SD 57101

1-800-536-8197; 1-605-336-7471

TTY/TDD: 711

www.shiine.net

TENNESSEE

TN SHIP

500 Deaderick Street, Suite 825
Nashville, TN 37243-0860

1-877-801-0044; 1-615-741-3309

TTY/TDD: 1-615-532-3893

www.state.tn.us/comaging/

TEXAS

**Health Information Counseling and
Advocacy Program (HICAP)**

701 W 51st Street
Austin, TX 78751

1-800-252-9240; 1-512-438-3538

TTY/TDD: 711

www.dads.state.tx.us

UTAH

**Senior Health Insurance Information
Program (SHIP)**

120 North 200 West, Room 325
Salt Lake City, UT 84103

1-877-424-4640; 1-801-538-4395

TTY/TDD: 711

www.hsdaas.utah.gov/insurance_programs.htm

VERMONT

State Health Insurance Assistance Program

481 Summer Street, Suite 101
St. Johnsbury, VT 05819

1-800-642-5119; 1-802-748-6622

TTY/TDD: 711

www.medicarehelpvt.net

VIRGINIA

**Virginia Insurance Counseling and
Assistance Program (VICAP)**

1610 Forest Avenue, Suite 102
Richmond, VA 23229

1-800-552-3402; 1-804-662-9354

TTY/TDD: 711

www.vda.virginia.gov

WASHINGTON

**Statewide Health Insurance Benefits
Advisors (SHIBA) Helpline**

P.O. Box 40256
Olympia, WA 98504-0256

1-800-562-6900;

TTY/TDD: 1-360-586-0241

www.insurance.wa.gov

Section

1. State Health Insurance Assistance (SHIP) (con't)

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WEST VIRGINIA
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West Virginia State Health Insurance Assistance Program (WV SHIP)

1900 Kanawha Blvd. E
Charleston, WV 25305

1-877-987-4463; 1-304-558-0004

TTY/TDD: 711

www.wvship.org

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WISCONSIN
.....

Wisconsin SHIP (SHIP)

1 West Wilson Street
Madison, WI 53707-7850

1-800-242-1060; 1-608-267-3203

TTY/TDD: 711

<http://www.dhs.wisconsin.gov/aging/EBS/ship.htm>

.....
WYOMING
.....

Wyoming State Health Insurance Information Program (WSHIIP)

106 W Adams, P.O. Box BD
Riverton, WY 82501

1-800-856-4398; 1-307-856-4466

TTY/TDD: 711

www.wyomingseniors.com

Section

2. Quality Improvement Organizations (QIO)

ALABAMA

Alabama Quality Assurance Foundation

2 Perimeter Park South, Suite 200 West
Birmingham, AL 35243

1-205-970-1600

TTY/TDD: 711

Fax: 1-205-970-1616

www.aqaf.com

ALASKA

Mountain-Pacific Quality Health

4241 B Street, Suite 303
Anchorage, AK 99503

1-877-561-3202, 1-907-561-3202

TTY/TDD: 711

Fax: 1-907-561-3204

www.mpqhf.com

ARIZONA

Health Services Advisory Group

3133 E Camelback Road, #300
Phoenix, AZ 85016

1-800-359-9909

TTY/TDD: 711

Fax: 1-602-241-0757

www.hsag.com

ARKANSAS

Arkansas Foundation for Medical Care

2201 Brooken Hill Drive
Fort Smith, AR 72908

1-800-272-5528

TTY/TDD: 711

Fax: 1-501-244-2101

www.afmc.org

CALIFORNIA

Health Services Advisory Group, Inc. (HSAG)

700 North Brand Blvd., Suite 370
Glendale, CA 91203

1-866-800-8749

TTY/TDD: 1-800-881-5980

<http://www.hsag.com/home.aspx>

COLORADO

Colorado Foundation for Medical Care

23 Inverness Way East, Suite 100
Englewood, CO 80112

1-800-950-8250

Fax: 1-303-695-3343

www.cfmc.org

CONNECTICUT

Qualidigm

1111 Cromwell Avenue, Suite 201
Rocky Hill, CT 06067-3454

1-800-553-7590

TTY/TDD: 711

Fax: 1-860-632-5865

www.qualidigm.org

DISTRICT OF COLUMBIA

Delmarva Foundation

2175 K Street, NW, Suite 250
Washington, DC 20037

1-800-937-3362

TTY/TDD: 711

Fax: 1-202-293-3253

www.delmarvafoundation.org

Section

2. Quality Improvement Organizations (QIO) (con't)

DELAWARE

Quality Insights of Delaware

3411 Silverside Road
Baynard Building, Suite 100
Wilmington, DE 19810-4812

1-866-475-9669

TTY/TDD: 711

Fax: 1-302-478-3873

www.qualityinsights.org

FLORIDA

Florida Medical Quality Assurance, Inc.

5201 W Kennedy Blvd., Suite 900
Tampa, FL 33609-1822

1-800-564-7490

TTY/TDD: 711

Fax: 1-813-354-0737

www.fmqa.com

GEORGIA

Georgia Medical Care Foundation

1455 Lincoln Pkwy., Suite 800
Atlanta, GA 30346

1-800-979-7217

TTY/TDD: 711

Fax: 1-404-982-7584

www.gmcf.org

HAWAII

Mountain-Pacific Quality Health

1360 S. Beretania Street, Suite 501
Honolulu, HI 96814

1-800-524-6550, 1-808-545-2550

TTY/TDD: 711

Fax: 1-808-440-6030

www.mpqhf.org

IDAHO

Qualis Health

720 Park Blvd., Suite 120
Boise, ID 83712

1-800-445-6941

TTY/TDD: 711

Fax: 1-208-343-4705

www.qualishealth.org

ILLINOIS

Illinois Foundation for Quality Health Care

711 Jorie Blvd., Suite #301
Oak Brook, IL 60523-2238

1-800-647-8089, 1-630-571-5540

TTY/TDD: 711

Fax: 1-630-571-5611

www.ifqhc.org

INDIANA

Health Care Excel, Inc.

2901 Ohio Blvd., Suite 112
P.O. Box 3713
Terre Haute, IN 47803-0713

1-800-288-1499

TTY/TDD: 711

Fax: 1-502-454-5113

www.hce.org

IOWA

Iowa Foundation for Medical Care

1779 West Lakes Pkwy.
West Des Moines, IA 50266

1-800-752-7014, 1-515-223-2900

TTY/TDD: 711

Fax: 1-515-222-2407

www.ifmc.org

Section

2. Quality Improvement Organizations (QIO) (con't)

KANSAS

Kansas Foundation for Medical Care

2947 SW Wanamaker Drive
Topeka, KS 66614-4193
1-800-432-0407, 1-785-273-2552
TTY/TDD: 711
Fax: 1-785-273-5130
www.kfmc.org

KENTUCKY

Health Care Excel Incorporated

1941 Bishop Lane, Suite 400
Louisville, KY 40218
1-800-288-1499, 1-502-454-5112
TTY/TDD: 711
Fax: 1-502-454-5113
www.hce.org

LOUISIANA

Louisiana Health Care Review

8591 United Plaza Blvd., Suite 270
Baton Rouge, LA 70809
1-800-433-4958, 1-225-926-6353
TTY/TDD: 711
Fax: 1-225-923-0957
www.lhcr.org

MARYLAND

Delmarva Foundation for Medical Care, Inc.

6940 Columbia Gateway Drive, Suite 420
Columbia, MD 21046-2877
1-800-937-3362
TTY/TDD: 711
Fax: 1-410-822-7291
www.dfmc.org

MASSACHUSETTS

MassPRO

245 Winter Street
Waltham, MA 02451
1-800-252-5533, 1-781-890-0011
TTY/TDD: 711
Fax: 1-781-487-0083
www.masspro.org

MICHIGAN

Michigan Peer Review Organization

22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335-2611
1-800-365-5899, 1-248-465-7300
TTY/TDD: 711
Fax: 1-248-465-7428
www.mpro.org

MINNESOTA

Stratis Health

2901 Metro Drive, Suite 400
Bloomington, MN 55425-1525
1-877-787-2847, 1-952-854-3306
TTY/TDD: 1-800-627-3529
Fax: 1-952-853-8503
www.stratishealth.org

MISSISSIPPI

Information and Quality Healthcare

385B Highland Colony Pkwy., Suite 504
Ridgeland, MS 39157
1-800-844-0600, 1-601-957-1575
TTY/TDD: 711
Fax: 1-601-956-1713
www.iquh.org

Section

2. Quality Improvement Organizations (QIO) (con't)

MISSOURI

Primaris

200 North Keene Street
Columbia, MO 65201

1-800-735-6776
TTY/TDD: 711
Fax: 1-573-817-8330
www.primaris.org

MONTANA

Qualis Health

3404 Cooney Drive
Helena, MT 59602

1-877-561-3202
TTY/TDD: 711
Fax: 1-907-560-3202
www.mpqhf.org

NEBRASKA

Cimro of Nebraska

1230 O Street, Suite 120
Lincoln, NE 68508

1-800-458-4262, 1-402-476-1399
TTY/TDD: 711
Fax: 1-402-476-1335
www.cimronebraska.org

NEVADA

Health Insight

6830 W. Oquendo Road, Suite 102
Las Vegas, NV 89118

1-800-274-2290
TTY/TDD: 711
Fax: 1-702-385-4586
www.healthinsight.org

NEW HAMPSHIRE

Northeast Health Care Quality Foundation

15 Old Rollinsford Road, Suite 302
Dover, NH 03820-2830

1-800-772-0151, 1-603-749-1641
TTY/TDD: 711
Fax: 1-603-749-1195
www.nhcqf.org

NEW JERSEY

Health Care Quality Strategies

557 Cranbury Road, Suite 21
East Brunswick, NJ 08816-4026

1-800-624-4557, 1-732-238-5570
TTY/TDD: 711
Fax: 1-732-238-7766
www.hqsi.org

NEW MEXICO

New Mexico Medical Review Association

5801 Osuna Road NE, Suite 200
Albuquerque, NM 87109

1-800-663-6351, 1-505-998-9898
TTY/TDD: 711
Fax: 1-505-998-9899
www.nmmra.org

NORTH CAROLINA

Medical Review of North Carolina, Inc.

100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598

1-800-682-2650, 1-919-380-9860
TTY/TDD: 1-800-735-2962
Fax: 1-919-380-7637
www2.thecarolinascener.org/ccme

Section

2. Quality Improvement Organizations (QIO) (con't)

NORTH DAKOTA

North Dakota Health Care Review, Inc.

800 31st Ave SW
Minot, ND 58701

1-800-472-2902, 1-701-852-4231

TTY/TDD: 711

Fax: 1-701-838-6009

www.ndhcri.org

OHIO

Ohio KePRO, Inc.

Rock Run Center
5700 Lombardo Center Drive, Suite 100
Seven Hills, OH 44131

1-800-589-7337

TTY/TDD: 1-800-325-0778

Fax: 1-216-447-7925

www.ohiokepro.com

OKLAHOMA

Oklahoma Foundation for Medical Quality

14000 Quail Springs Pkwy., Suite 400
Oklahoma City, OK 73134-2600

1-800-522-3414, 1-405-840-2891

TTY/TDD: 711

Fax: 1-405-858-9097

www.ofmq.com

OREGON

Acumentra Health

2020 SW Fourth Avenue, Suite 520
Portland, OR 97201-4960

1-800-344-4354, 1-503-279-0100

TTY/TDD: 711

Fax: 1-503-279-0190

www.acumentra.org

PENNSYLVANIA

Quality Insights of Pennsylvania

2601 Market Place Street, Suite 320
Harrisburg, PA 17110

1-800-322-1914

TTY/TDD: 711

Fax: 1-717-671-5970

www.qipa.org

RHODE ISLAND

Rhode Island Quality Partners, Inc.

235 Promenade Street, Suite 500
Box 18
Providence, RI 02908

1-800-662-5028, 1-401-528-3200

TTY/TDD: 711

Fax: 1-401-528-3210

www.riqualitypartners.org

SOUTH CAROLINA

The Carolinas Center for Medical Excellence

246 Stoneridge Drive, Suite 200
Columbia, SC 29210

1-800-922-3089, 1-803-251-2215

TTY/TDD: 1-800-735-8583

Fax: 1-803-255-0897

www.thecarolinascenter.org

SOUTH DAKOTA

South Dakota Foundation for Medical Care

2600 West 49th Street, Suite 300,
P.O. Box 7406
Sioux Falls, SD 57117-7406

1-605-336-3505

TTY/TDD: 711

Section

2. Quality Improvement Organizations (QIO) (con't)

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TENNESSEE
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Qsource

3175 Lenox Park Blvd., Suite 309
Memphis, TN 38115
1-800-528-2655, 1-901-682-0381
TTY/TDD: 711
Fax: 1-901-761-3786
www.qsource.org

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TEXAS
.....

TMF Health Quality Institute

Bridgepoint I, Suite 300
5918 West Courtyard Drive
Austin, TX 78730-5036
1-800-725-9216, 1-512-329-6610
TTY/TDD: 711
Fax: 1-512-327-7159
www.tmf.org

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UTAH
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HealthInsight

348 East 4500 South, Suite 300
Salt Lake City, UT 84107
1-801-892-0155
TTY/TDD: 711
Fax: 1-801-892-0160
www.healthinsight.org

.....
WASHINGTON
.....

Qualis Health

10700 Meridian N, Suite 100,
P.O. Box 33400
Seattle, WA 98133
1-877-575-8309
TTY/TDD: 711
Fax: 1-206-368-2419
www.qualishealth.org

.....
WEST VIRGINIA
.....

West Virginia Medical Institute, Inc.

3001 Chesterfield Place
Charleston, WV 25304
1-800-642-8686, 1-304-346-9864
TTY/TDD: 711
www.wvmi.org

Section

3. State Medicaid Offices

ALABAMA

Alabama Medicaid Agency

P.O. Box 5624
Montgomery, AL 36103-5624
1-800-362-1504, 1-334-206-5175
TTY/TDD: 711
www.medicaid.alabama.gov

ALASKA

Alaska Department of Health & Social Services

350 Main Street, Room 404, P.O. Box 110601
Juneau, AK 99811-0601
1-602-417-4000, 1-800-770-5650
TTY/TDD: 711
www.hss.state.ak.us/dpa

ARIZONA

Health Care Cost Containment of Arizona

801 E. Jefferson, MD 4100
Phoenix, AZ 85034
1-800-654-8713, 1-602-417-4000
TTY/TDD: 711
<http://www.azahcccs.gov>

ARKANSAS

Department of Human Services of Arkansas

P.O. Box 1437, Slot S401
Donaghey Plaza South
Little Rock, AR 72203-1437
1-800-482-8988
TTY/TDD: 1-800-682-8820
www.medicaid.state.ar.us

COLORADO

Department of Health Care Policy and Financing of Colorado

1570 Grant Street
Denver, CO 80203
1-303-866-3513, 1-303-866-3883
TTY/TDD: 1-800-659-2656
<http://www.chcpf.state.co.us>

CONNECTICUT

Department of Social Services of Connecticut

25 Sigourney Street
Hartford, CT 06106-5033
1-800-842-1508, 1-860-509-8000
TTY/TDD: 1-800-842-4524
www.ct.gov/dss

DELAWARE

Delaware Health and Social Services

Herman Holloway Sr. Campus
1901 N. DuPont Highway
New Castle, DE 19720
1-800-372-2022, 1-302-255-9040
TTY/TDD: 711
www.dhss.delaware.gov/dhss/dmma/medicaid.html

DISTRICT OF COLUMBIA

DC Medicaid

1820 Jefferson Place, NW
Washington, DC 20036
1-202-442-5988
TTY/TDD: 711
www.doh.dc.gov

Section

3. State Medicaid Offices (con't)

FLORIDA

**Agency for Health Care Administration
of Florida**

1317 Winewood Blvd, Building 1, Room 202
Tallahassee, FL 32399-1734

1-888-367-6554

TTY/TDD: 1-800-653-9803

www.medicaidoptions.net

GEORGIA

Georgia Department of Community Health

2 Peachtree Street
Atlanta, GA 30303

1-800-869-1150

TTY/TDD: 711

www.dch.georgia.gov

HAWAII

Department of Human Services of Hawaii

1390 Miller Street, Room 209
Honolulu, HI 96813

1-800-316-8005

TTY/TDD: 711

<http://www.med-quest.us>

IDAHO

Idaho Department of Health and Welfare

3232 Elder
Boise, ID 83705

1-800-926-2588

TTY/TDD: 711

<http://healthandwelfare.idaho.gov>

ILLINOIS

**Illinois Department of Healthcare
and Family Services**

201 South Grand Avenue East
Springfield, IL 62763

1-800-226-0768, 1-800-782-71-860

1-800-545-2200 (Spanish)

TTY/TDD: 1-800-526-5812

www.hfs.illinois.gov

INDIANA

**Family and Social Services Administration
of Indiana**

402 W. Washington Street, P.O. Box 7083
Indianapolis, IN 46207

1-800-889-9949, 1-317-233-4454

TTY/TDD: 1-800-743-3333

<http://member.indianamedicaid.com/>

IOWA

Department of Human Services of Iowa

Hoover State Office Building, 5th Floor
Des Moines, IA 50319

1-800-338-8366, 1-515-281-4115

TTY/TDD: 711

www.dhs.state.ia.us

KANSAS

**Kansas Department on Aging New
England Building**

503 S. Kansas Ave.
Topeka, KS 66603-3404

1-800-432-3535

TTY/TDD: 1-785-291-3167

www.agingkansas.org

Section

3. State Medicaid Offices (con't)

KENTUCKY

Cabinet for Health Services of Kentucky

275 East Main Street
Frankfort, KY 40601

1-800-635-2570, 1-502-564-4321

TTY/TDD: 1-800-627-4702

www.chfs.ky.gov

LOUISIANA

**Louisiana Department of Health
and Hospital**

P.O. Box 91278
Baton Rouge, LA 70821-9278

1-888-342-6207, 1-225-342-9500

TTY/TDD: 1-225-216-7387

www.medicaid.dhh.louisiana.gov

MAINE

**Maine Department of Health
and Human Services**

442 Civic Center Drive
11 State House Station
Augusta, ME 04333

1-800-977-6740, 1-207-287-9202

TTY/TDD: 1-800-606-0215

www.maine.gov/dhhs/bms

MARYLAND

**Maryland Department of Health
and Mental Hygiene**

201 West Preston Street
Baltimore, MD 21201-2301

1-800-492-5231, 1-410-767-5800

TTY/TDD: 711

www.dhmh.state.md.us

MASSACHUSETTS

**Office of Health and Human Services
of Massachusetts**

One Ashburton Place, 11th Floor
Boston, MA 02108

1-800-841-2900, 1-617-573-1770

TTY/TDD: 1-800-530-7570

www.mass.gov/masshealth

MICHIGAN

Michigan Department of Community Health

Capital View Building, 201 Townsend Street
Lansing, MI 48913

1-800-642-3195, 1-517-373-3740

TTY/TDD: 1-517-373-3573

www.michigan.gov/mdch

MINNESOTA

**Department of Human Services of Minnesota
– MinnesotaCare**

P.O. Box 64838
Street Paul, MN 55164

1-800-657-3739, 1-651-431-2000

TTY/TDD: 711

www.dhs.state.mn.us

MISSISSIPPI

Office of the Governor of Mississippi

550 High Street, Suite 1000
Walter Sillers Building
Jackson, MS 39201-1399

1-800-421-2408, 1-601-359-6050

TTY/TDD: 711

www.medicaid.ms.gov

Section

3. State Medicaid Offices (con't)

MISSOURI

**Department of Social Services of Missouri –
MO HealthNet Division**

P.O. Box 6500, 615 Howerton Court
Jefferson City, MO 65102

1-800-392-2161, 1-800-735-2466

TTY/TDD: 1-800-735-2966

<http://www.dss.mo.gov/fsd/index.htm>

MONTANA

**Montana Dept. of Public Health and
Human Services Division of Child
and Adult Health Resources**

1400 Broadway, Cogswell Building,
P.O. Box 202951, Helena, MT 59620

1-800-362-8312, 1-406-444-4540

TTY/TDD: 1-406-444-2590

www.dphhs.mt.gov

NEBRASKA

**Nebraska Department of Health and Human
Services System**

P.O. Box 95026
Lincoln, NE 68509-5044

1-800-430-3244, 1-402-471-3121

TTY/TDD: 1-402-471-9570

www.hhs.state.ne.us

NEVADA

**Nevada Department of Human Resources,
Aging Division**

1210 S. Valley View, Suite 104
Las Vegas, NV 89102

1-702-668-4200, 1-775-684-0800

TTY/TDD: 711

<http://dhcfp.state.nv.us>

NEW HAMPSHIRE

**New Hampshire Department of Health
and Human Services**

129 Pleasant Street
Concord, NH 03301-3857

1-800-852-3345, 1-603-271-5254

TTY/TDD: 1-800-735-2964

www.dhhs.state.nh.us

NEW JERSEY

**Department of Human Services
of New Jersey**

P.O. Box 712, Quakerbridge Plaza, Building 7
Trenton, NJ 08625-0712

1-800-356-1561, 1-609-588-2600

TTY/TDD: 711

www.state.nj.us/humanservices/dmahs

NEW MEXICO

**Department of Human Services
of New Mexico**

P.O. Box 2348
Santa Fe, NM 87504-2348

1-888-997-2583, 1-505-827-3184

TTY/TDD: 711

<http://www.state.nm.us/hsd/mad/Index.html>

NEW YORK

New York State Department of Health

Corning Tower, Empire State Plaza
Albany, NY 12223

1-800-541-2831, 1-518-486-9057

TTY/TDD: 711

<http://www.health.state.ny.us>

Section

3. State Medicaid Offices (con't)

NORTH CAROLINA

**North Carolina Department of Health
and Human Services**

Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2012

1-800-662-7030, 1-919-733-4534

TTY/TDD: 1-877-733-4851

www.dhhs.state.nc.us/dma/mqb.html

NORTH DAKOTA

**Department of Human Services of North
Dakota – Medical Services**

600 E. Boulevard Avenue, Dept 325
Bismarck, ND 58505-0250

1-800-755-2604, 1-701-328-2310

TTY/TDD: 1-701-328-3480

www.nd.gov/dhs/

OHIO

**Department of Job and Family Services
of Ohio – Ohio Health Plans**

30 E. Broad Street, 32nd Floor
Columbus, OH 43215

1-877-852-0010, 1-614-644-0140

TTY/TDD: 1-800-292-3572

<http://jfs.ohio.gov/ohp/>

OKLAHOMA

Health Care Authority of Oklahoma

2401 N.W. 23rd Street, Suite 1A
Oklahoma City, OK 73107

1-800-522-0310, 1-405-522-5818

TTY/TDD: 1-405-522-7179

www.oregon.gov/dhs/index.shtml

OREGON

Oregon Department of Human Services

500 Summer Street NE
Salem, OR 97301-1079

1-800-359-9517, 1-503-945-5772

TTY/TDD: 1-800-375-2863

www.dpw.state.pa.us/omap/dpwomap.asp

PENNSYLVANIA

**Department of Public Welfare
of Pennsylvania**

Health and Welfare Building, Rm 515
P.O. Box 2675
Harrisburg, PA 17105

1-800-692-7462, 1-877-724-3258

TTY/TDD: 1-717-705-7103

www.dpw.state.pa.us

RHODE ISLAND

**Department of Human Services
of Rhode Island**

Louis Pasteur Building
600 New London Avenue
Cranston, RI 02921

1-401-462-5300, 1-401-462-5300

TTY/TDD: 1-401-462-3363

www.dhs.ri.gov

SOUTH CAROLINA

**South Carolina Department of Health
and Human Services**

P.O. Box 8206
Columbia, SC 29202

1-888-549-0820, 1-803-898-2500

TTY/TDD: 711

<http://www.dhhs.state.sc.us>

Section

3. State Medicaid Offices (con't)

SOUTH DAKOTA

**Department of Social Services
of South Dakota**

700 Governors Drive, Richard F. Kneip Bldg
Pierre, SD 57501

1-800-597-1603, 1-605-773-3495

TTY/TDD: 711

www.state.sd.us/social/medical

TENNESSEE

Bureau of TennCare

310 Great Circle Road
Nashville, TN 37243

1-866-311-4287, 1-615-741-3111

TTY/TDD: 711

<http://state.tn.us/tenncare>

TEXAS

**Health and Human Services Commission
of Texas**

4900 N. Lamar Boulevard, 4th Floor
Austin, TX 78701

1-877-541-7905, 1-512-458-7111

TTY/TDD: 711

www.hhsc.state.tx.us

UTAH

Utah Medicaid Program

288 North 1460 West
Salt Lake City, UT 84114

1-801-538-6155, 1-801-538-6155

TTY/TDD: 711

www.health.utah.gov/medicaid

VERMONT

Agency of Human Services of Vermont

103 South Main Street
Waterbury, VT 5676

1-800-250-8427, 1-802-241-1282

TTY/TDD: 711

www.ovha.vermont.gov

WASHINGTON

**Department of Social and Health Services
of Washington**

P.O. Box 45505
Olympia, WA 98504-5130

1-800-562-3022

TTY/TDD: 711

www.adsa.dshs.wa.gov

WEST VIRGINIA

**West Virginia Department of Health
and Human Resources**

350 Capital Street, Room 251
Office of Administration
Charleston, WV 25301-3709

1-800-642-8589, 1-304-558-1703

TTY/TDD: 711

www.dhhr.wv.gov/bms/Pages/default.aspx

Section

4. State Medicare Offices

Medicare

1-800-MEDICARE

(1-800-633-4227)

TTY/TDD: 1-877-486-2048

Seven days a week, 24 hours a day

www.medicare.gov

CALIFORNIA

San Francisco Regional Office

90 - 7th Street, Suite 5-300

San Francisco, CA 94103-6706

COLORADO

Denver Regional Office

1600 Broadway, Suite 700

Denver, CO 80202-4367

GEORGIA

Atlanta Regional Office

61 Forsyth Street, SW, Suite 4T20

Atlanta, GA 30303-8909

ILLINOIS

Chicago Regional Office

233 North Michigan Avenue, Suite 600

Chicago, IL 60601

MASSACHUSETTS

Boston Regional Office

JFK Federal Building, Suite 2325

Boston, MA 02203-0003

MISSOURI

Kansas City Regional Office

601 E. 12th Street, Suite 235

Kansas City, MO 64106

NEW YORK

New York Regional Office

26 Federal Plaza, Room 3811

New York, NY 10278-0063

PENNSYLVANIA

Philadelphia Regional Office

150 South Independence Mall West

Public Ledger Bldg.

Philadelphia, PA 19106

TEXAS

Dallas Regional Office

1301 Young Street, Room 714

Dallas, TX 75202

WASHINGTON

Seattle Regional Office

2201 6th Ave, Mailstop 40

Seattle, WA 98121

Section

5. State Pharmacy Assistance Program (SPAP)

CONNECTICUT

Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE)

P.O. Box 5011
Hartford, CT 06102

1-860-269-2029

TTY/TDD: 711

<http://www.connpace.com/>

CONNECTICUT

Maryland Senior Prescription Drug Assistance Program SPDAP

c/o Pool Administrators
628 Hebron Avenue, Suite 212
Glastonbury, CT 06033

1-800-551-5995

TTY/TDD: 1-800-877-5156

Fax: 1-800-847-8217

www.marylandspdap.com

DELAWARE

Delaware Prescription Assistance Program

P.O. Box 950
New Castle, DE 19720

1-800-996-9969

TTY/TDD: 711

HAWAII

State Pharmacy Assistance Program

P.O. Box 700220
Kapolei, HI 96709

1-866-878-9769

TTY/TDD: 711

www.med-quest.us/eligibility/EligPrograms-SPAP.html

ILLINOIS

Illinois Cares Rx

P.O. Box 19003
Springfield, IL 62794

1-800-624-2459

TTY/TDD: 711

www.illinoiscaresrx.com

INDIANA

HoosiersRX

P.O. Box 6224
Indianapolis, IN 46206

1-866-267-4679, 1-866-267-4679

TTY/TDD: 711

www.in.gov/fssa/elderly/hoosierx/

Section

5. State Pharmacy Assistance Program (SPAP) (con't)

MAINE

**Maine Low Cost Drugs for the Elderly
or Disabled Program**

Office of MaineCare Services,
442 Civic Center Drive
Augusta, ME 04333

1-866-796-2463

TTY/TDD: 1-800-606-0215

[www.maine.gov/dhhs/beas/resource/
lc_drugs.htm](http://www.maine.gov/dhhs/beas/resource/lc_drugs.htm)

MASSACHUSETTS

Massachusetts Prescription Advantage

P.O. Box 15153
Worcester, MA 01615

1-800-243-4636

TTY/TDD: 1-877-610-0241

[http://www.mass.gov/?pageID=eldershomepag
e&L=1&L0=Home&sid=Eelders](http://www.mass.gov/?pageID=eldershomepage&L=1&L0=Home&sid=Eelders)

MISSOURI

Missouri Rx Plan

P.O. Box 6500
Jefferson City, MO 65102

1-800-375-1406

TTY/TDD: 1-800-735-2966

www.morx.mo.gov

MONTANA

Montana Big Sky Rx Program

P.O. Box 202915
Helena, MT 59620

1-866-369-1233

TTY/TDD: 711

[www.dphhs.mt.gov/prescriptiondrug/
bigsky.shtml](http://www.dphhs.mt.gov/prescriptiondrug/bigsky.shtml)

NEVADA

Nevada Senior Rx Program

Department of Health and Human Services,
3416 Goni Road, Suite B-113
Carson City, NV 89706

1-866-303-6323, 1-775-687-7555

TTY/TDD: 711

Fax: 1-775-687-3499

<http://dhhs.nv.gov/SeniorRx.htm>

NEW JERSEY

**New Jersey Pharmaceutical Assistance
to the Aged and Disabled Program (PAAD)**

PAAD-HAAAD, P.O. Box 715
Trenton, NJ 08625

1-800-792-9745

TTY/TDD: 711

[www.state.nj.us/health/seniorbenefits/
paad.shtml](http://www.state.nj.us/health/seniorbenefits/paad.shtml)

Section

5. State Pharmacy Assistance Program (SPAP) (con't)

NEW YORK

New York State Elderly Pharmaceutical Insurance Coverage (EPIC)

P.O. Box 15018
Albany, NY 12212

1-800-332-3742

TTY/TDD: 1-800-290-9138

www.health.state.ny.us/nysdoh/epic/faq.htm

PENNSYLVANIA

Pharmaceutical Assistance Contract for the Elderly PACE Program

1st. Health Services
4000 Crums Mill Road, Suite 301
Harrisburg, PA 17112

1-800-225-7223

TTY/TDD: 711

Fax: 1-717-651-3608

www.aging.state.pa.us/portal/server.pt/community/pace_pacenet/17944

RHODE ISLAND

Attention RIPAE

Rhode Island Department of Elderly Affairs,
74 West Road, Hazard Building, Second Floor
Cranston, RI 02920

1-401-462-3000

TTY/TDD: 711

www.dea.state.ri.us/programs/

SOUTH CAROLINA

South Carolina Gap Assistance Pharmacy Program for Seniors (GAPS)

P.O. Box 8206
Columbia, SC 29202

1-888-549-0820

TTY/TDD: 711

www.dhhs.state.sc.us

VERMONT

Vermont V Pharm

312 Hurricane Lane, Suite 201
Willston, VT 05495

1-800-250-8427

TTY/TDD: 1-888-834-7898

<http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance>

WASHINGTON

Washington State Health Insurance Pharmacy Assistance Program

P.O. Box 1090
Great Bend, KS 67530

1-800-877-5187

TTY/TDD: 711

www.wship.org

Section

6. Civil Rights Commission Contact Information

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REGION I

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
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Office for Civil Rights

JFK Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, 1-617-565-3809
TTY/TDD: 1-617-565-1343
www.hhs.gov/ocr

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REGION II

New Jersey, New York, Puerto Rico, and Virgin Islands
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Office for Civil Rights

26 Federal Plaza, Suite 3312
New York, NY 10278
1-800-368-1019, 1-212-264-3039
TTY/TDD: 1-212-264-2355
www.hhs.gov/ocr

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REGION III

Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia
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Office for Civil Rights

Public Ledger Building
150 South Independence Mall West, Suite 372
Philadelphia, PA 19106
1-800-368-1019, 1-215-861-4431
TTY/TDD: 1-215-861-4440
www.hhs.gov/ocr

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REGION IV

Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee
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Office for Civil Rights

61 Forsyth Street, Suite 3 B70
Atlanta, GA 30303
1-800-368-1019, 1-404-562-7881
TTY/TDD: 1-404-562-7884
www.hhs.gov/ocr

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REGION V

Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin
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Office for Civil Rights

233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, 1-312-886-1807
TTY/TDD: 1-312-353-5693
www.hhs.gov/ocr

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REGION VI

Arkansas, Louisiana, New Mexico, Oklahoma, and Texas
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Office for Civil Rights

1301 Young Street, Suite 1169
Dallas, TX 75202
1-800-368-1019, 1-214-767-0432
TTY/TDD: 1-214-767-8940
www.hhs.gov/ocr/

Section

6. Civil Rights Commission Contact Information (con't)

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REGION VII

Iowa, Kansas, Missouri, and Nebraska
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Office for Civil Rights

601 East 12th Street, Room 248
Kansas, MO 64106

1-800-368-1019, 1-816-426-3686

TTY/TDD: 1-816-426-7065

www.hhs.gov/ocr

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REGION X

Alaska, Idaho, Oregon, and Washington
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Office for Civil Rights

2201 6th Avenue, M/S Rx 11
Seattle, WA 98121

1-800-368-1019, 1-206-615-2297

TTY/TDD: 1-206-615-2296

www.hhs.gov/ocr

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REGION VIII

**Colorado, Montana, North Dakota, South
Dakota, Utah, and Wyoming**
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Office for Civil Rights

Federal Office Building, 1961 Stout Street
Denver, CO 80294

1-800-368-1019, 1-303-844-2025

TTY/TDD: 1-303-844-3439

www.hhs.gov/ocr

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REGION IX

**American Samoa, Arizona, California,
Guam, Hawaii, and Nevada**
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Office for Civil Rights

90 7th Street, Suite 4-100
San Francisco, CA 94103

1-800-368-1019, 1-415-437-8329

TTY/TDD: 1-415-437-8311

www.hhs.gov/ocr



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