EVIDENCE OF COVERAGE:

Your Medicare Prescription Drug Coverage as a Member of Anthem Blue Cross MedicareRx Premier from Anthem Blue Cross Life and Health Insurance Company

University of California High Option Plan
Retirees with Medicare Prescription Drug Benefits
January 1, 2008

This booklet gives the details about your Medicare prescription drug coverage and explains how to get the prescription drugs you need. This booklet is an important legal document. Please keep it in a safe place.

Anthem Blue Cross MedicareRx Customer Service:

For help or information, please call customer service.
Calls to these numbers are free.

1-866-470-6265

1-800-425-5705 for TTY/TTD users

Hours of Operation:

8 a.m. to 8 p.m.

7 days a week

Prescription Drug Benefits	What you must pay for these covered services
Formulary	**Premier Medicare D**
Formulary Type	**Open**
Deductible	**$0**
Mandatory Generic	**No**
Retail	
Supply Limits	**30-day supply**
• Generic	$15 copay
• Brand	$25 copay
• Non-Formulary	$40 copay
• Self Administered Injectable Drugs (other than Insulin), Specialty Drugs and Vaccines	Paid at the generic or brand copay level
• Contraceptive Devices, limited to one per year; Diabetic Supplies (other than Diabetic Syringes)	No copayment
• Diabetic Syringes	$25
• Purchase a 60 or 90 day supply through select retail pharmacies that have contracted to dispense an extended supply	1 copay for each 30-day supply
Mail Order	
Supply Limits	**90-day supply**
• Generic	$30 copay
• Brand	$50 copay
• Non-Formulary	$80 copay
• Self Administered Injectable Drugs (other than Insulin), Specialty Drugs and Vaccines	Paid at the generic or brand copay level
• Contraceptive Devices, limited to one per year; Diabetic Supplies (other than Diabetic Syringes)	No copayment
• Diabetic Syringes	$50
After you have paid $1,000 in out-of-pocket expenses	0 copay (zero copay)
Out-of-Network Benefits You will need to pay the full cost of the drug at the pharmacy and submit a claim for reimbursement	Copay plus the amount over Medicare allowed amount.
Prescription Drug Purchases outside the USA	Covered at the copay level above.

Table of Contents

Section 1 Introduction

Welcome to Anthem Blue Cross MedicareRx!

Anthem Blue Cross MedicareRx is offered by Anthem Blue Cross Life and Health Insurance Company and is a Medicare Prescription Drug Plan.

Thank you for your membership in Anthem Blue Cross MedicareRx; you are getting your Medicare prescription drug coverage through this plan. Anthem Blue Cross MedicareRx is not a "Medigap" Medicare Supplement Insurance policy.

This Evidence of Coverage, Annual Notice of Change (ANOC), formulary, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of this plan. The information in this Evidence of Coverage is in effect for the time period from January 1, 2008 – December 31, 2008.

This Evidence of Coverage will explain to you:

- what is covered by this plan and what isn't covered
- how to get your prescriptions filled including some rules you must follow
- what you will have to pay for your prescriptions
- what to do if you are unhappy about something related to getting your prescriptions filled
- how to leave this plan

Throughout the remainder of this Evidence of Coverage, we refer to Anthem Blue Cross MedicareRx as "plan" or "this plan."

If you need this Evidence of Coverage in a different format; such as Spanish, large print, or audio tapes) please call us so we can send you a copy.

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.

Telephone numbers and other information for reference

How to contact Anthem Blue Cross MedicareRx Customer Service
If you have any questions or concerns, please call or write to Anthem Blue Cross MedicareRx Customer Service. We will be happy to help you.

Call 1-866-470-6265 This number is also on the cover of this booklet for easy reference. Calls to this number are free.

TTY/TDD 1-800-425-5705 This number requires special telephone equipment. It is also listed on the cover of this booklet for easy reference. Calls to this number are free.

Write Anthem Blue Cross MedicareRx
P.O. Box 110
Fond du Lac, Wisconsin 54936

Contact information for grievances, coverage determinations and appeals

Part D Coverage Determinations

Call 1-866-470-6265 Calls to this number are free.

TTY/TDD 1-800-425-5705 This number requires special telephone equipment. It is also listed on the cover of this booklet for easy reference. Calls to this number are free.

Fax 1-888-458-1407

Write Anthem Blue Cross MedicareRx
P.O. Box 110
Fond du Lac, Wisconsin 54936

For information about Part D coverage determinations, see *Section 8*.

Part D Grievances

Call 1-866-470-6265 Calls to this number are free.

TTY/TDD 1-800-425-5705 This number requires special telephone equipment. It is also listed on the cover of this booklet for easy reference. Calls to this number are free.

Fax 1-888-458-1407

Write Anthem Blue Cross MedicareRx, Grievance and Appeals Unit
P.O. Box 1975
Fond du Lac, Wisconsin 54936-1975

For information about Part D grievances, see *Section 7*.

Part D Appeals

Call 1-866-470-6265 Calls to this number are free.

TTY/TDD 1-800-425-5705 This number requires special telephone equipment. It is also listed on the cover of this booklet for easy reference. Calls to this number are free.

Fax 1-888-458-1407

Write Anthem Blue Cross MedicareRx, Prescription Drug Plan
P.O. Box 1975
Fond du Lac, Wisconsin 54936-1975

For information about Part D appeals, see *Section 8*

SHIP or State Health Insurance Assistance Program –
a state program that gives free local health insurance counseling to people with Medicare

SHIPs is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies.

See the end of this Evidence of Coverage to locate the SHIPs office in your area. You may also find the web site for your local SHIP at www.medicare.gov on the Web. Under "Search Tools," select "Helpful Phone Numbers and Websites."

QIO or Quality Improvement Organization –
a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare

"QIO" stands for Quality Improvement Organization. The QIO is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See *Sections 7 and 8* for more information about complaints, appeals and grievances.

See the end of this Evidence of Coverage to locate the QIO office in your area.

How to contact the Medicare program

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare plans (including this plan). Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.

- Visit www.medicare.gov. This is the official government web site for Medicare information. This web site gives you up-to-date information about Medicare, nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and web sites." If you don't have a computer, your local library or senior center may be able to help you visit this web site using its computer.

Medicaid -

a state government agency that handles health care programs for people with limited resources

Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, see the end of this Evidence of Coverage to locate the Medicaid office in your area.

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit www.ssa.gov on the Web.

SPAP or State Pharmacy Assistance Program –

an organization in your state that provides financial help for prescription drugs

SPAPs are state organizations that provide limited income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. See the end of this Evidence of Coverage to locate the SPAP office in your area.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "group") coverage

If you or your spouse get your benefits from your current or former employer or union, or from your spouse's current or former employer or union, call your employer's or union's benefits administrator or customer service if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: Your (or your spouse's) employer/union benefits may change, or you or your

spouse may lose the benefits, if you or your spouse enrolls in Medicare Part D outside your employer's coverage. Call your employer's or union's benefits administrator or customer service to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

Eligibility requirements

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

What extra help is available?

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 will get help paying for your Medicare drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. **You automatically qualify for extra help and don't need to apply**. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.
2. **You apply and qualify**. You may qualify if your yearly income in 2007 is less than $15,315 (single with no dependents) or $20,535 (married and living with your spouse with no dependents), and your resources are less than $11,710 (single) or $23,410 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2007 and will change in 2008. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. The amount of extra help you get is based on your income and resources.

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" 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."

We will credit the amount of the extra help received to your prior employer/union's bill on your behalf. If your prior 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/union must apply the subsidy toward the amount you would contribute.

What if you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount when you get your prescription at a pharmacy, this plan has established a process that will allow you to provide evidence of your proper copayment level.

Please fax or mail a copy of your paperwork showing you qualify for subsidy. Below are examples of what paperwork you can provide:

Proof of LIS Status

- a copy of a member's Medicaid card that includes the member's name and the eligibility date during the discrepant period
- a copy of a letter from the State or SSA showing Medicare Low-Income Subsidy status
- the date that a verification call was made to the State Medicaid Agency, the name and telephone number of the state staff person who verified the Medicaid period, and the Medicaid eligibility dates confirmed on the call
- a copy of a state document that confirms active Medicaid status during the discrepant period
- a screen-print from the State's Medicaid systems showing Medicaid status during the discrepant period; or
- evidence at point-of-sale of recent Medicaid billing and payment in the pharmacy's patient profile, backed up by one of the above indicators post point-of-sale
- a print out from the State electronic enrollment file showing Medicaid status during the discrepant period

Proof of Institutional Status for a Full-Benefit Dual Eligible

- a remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period
- a copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- a screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period

Once we have received your paperwork and verified your status, we will call you so you can begin filling your prescriptions at the low-income copay.

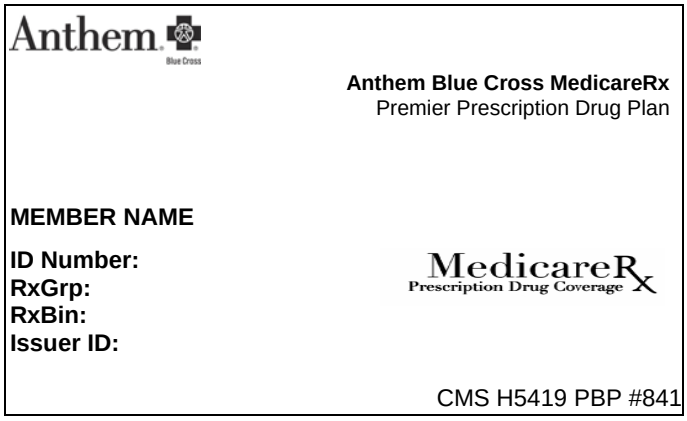
Please be assured that if you overpay your copayment, we will generally reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. Of course, if the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt 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.

Use your plan membership card, not your red, white, and blue Medicare card

Now that you are a member of this plan, you must use our membership card for prescription drug coverage at network pharmacies. While you are a member of this plan and using plan services, you must use your plan membership card instead of your red, white, and blue Medicare card to get covered drugs.

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

Here is a sample card to show you what it looks like:



The Pharmacy Directory gives you a list of plan network pharmacies

As a member of this plan we will send you a complete Pharmacy Directory, which gives you a list of our network pharmacies, at least every three years, and an update of our Pharmacy Directory every year that we don't send you a complete Pharmacy Directory. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from customer service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our web site.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits that we provide.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- a list of prescriptions you filled during the month, as well as the amount paid for each prescription
- information about how to request an exception and appeal our coverage decisions
- a description of changes to the formulary affecting the prescriptions your have gotten filled that will occur at least 60 days in the future
- a summary of your coverage this year, including information about:
  - **Annual deductible** — The amount you pay, and/or others pay before you start getting prescription coverage. (Please refer to the benefit summary in the front of this book to see if your plan has a deductible.)
  - **Amount paid for prescriptions** — The amounts paid that count towards your initial coverage limit
  - **Total out-of-pocket costs that count toward catastrophic coverage** — The total amount you and/or others have spent on prescription drugs that count towards your qualifying for catastrophic coverage. This total includes the amounts spent for your deductible, copayment and coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.) (Please refer to the benefit summary in the front of this book to see your plans Catastrophic Coverage Amount.)

What should you do if you don’t get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact customer service.

The geographic service area for this plan.

In order to enroll in this prescription drug plan your permanent residence must be in its geographic service area. However, when traveling within the United States members have access to our national network of pharmacies who have agreed to participate in the Medicare Part D program. Customer service can assist you in finding a contracted pharmacy.

In certain situations, employer groups are allowed to cover their out of state retirees under this plan.

Section 2 How you get outpatient prescription drugs

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

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

If you are currently enrolled in an SPAP, you may get help paying your premiums, deductibles, and or coinsurance/copayments. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction section for more information. See the end of this Evidence of Coverage to locate the SPAP office in your area.

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 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 adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If you are a member of an employer or retiree group

The benefits described in this evidence of coverage are a part of your group employer/ union retiree health plan. If you have questions about eligibility rules, open enrollment periods or your share of premium, please call your employer's benefits administrator.

Using network pharmacies to get your prescription drugs covered by us

What are network pharmacies?

By using a network pharmacies to get your prescription drugs, you will minimize your out of pocket costs.

What is a "network pharmacy"? A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drug. Once you go to one, you aren't required to continue going to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must either have a new prescription written by a doctor or have the

previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.

We have a list of retail pharmacies in our network at which you can obtain an extended supply of all medications. Please refer to your pharmacy listing or call customer service to locate a retail pharmacy in our network at which you can obtain an extended supply of medications.

What are "covered drugs"? The term "covered drugs" means all of the outpatient prescription drugs that are covered by this plan. Covered drugs are listed in our formulary.

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call 1-800-281-8172 to obtain the necessary information to pay the full cost of the prescription (rather than paying just your copayment or coinsurance). If this happens, you may ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another plan network pharmacy. Please refer to your pharmacy listing or call customer service to find another network pharmacy in your area.

How do you fill a prescription through this plan's network mail-order-pharmacy service?

You can use our mail order service, NextRx, to fill prescriptions for almost any drug that is marked as a mail-order drug on the formulary list. Order forms can be obtained by contacting customer service.

When you order prescription drugs through our network mail order pharmacy service, you must order at least a -day supply of the drug. Please check your benefit summary, located in the front of this booklet to verify the mail order supply of mail-order drugs.

Generally, it takes us 12 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If your mail order is delayed, we will notify you and provide instructions on how to obtain your prescription in the interim.

You are not required to use our mail order services to get an extended supply of mail order drugs. You can also get an extended supply through some retail network pharmacies. Some retail pharmacies may provide an extended supply, but charge a

higher copayment than our mail order service. Please call customer service, at the number on the cover of this booklet, to find out which retail pharmacies offer an extended supply.

Filling prescriptions outside the network

We have network pharmacies outside of the service area where you can get your drugs covered as a member of this plan. **Before you fill your prescription in these situations, call customer service to see if there is a network pharmacy in your area where you can fill your prescription**. If you do go to an out-of-network pharmacy, you may have to pay the full cost (rather than paying just your copayment/coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see *Section 4*). To learn how to submit a paper claim, please refer to the paper claims process described next.

In addition to paying the copayments/coinsurances listed on your benefit summary 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.

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

You can call customer service at the number listed on the cover of this booklet to find out if there is a network pharmacy in the area where you are traveling. We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and territories, even for a medical emergency.

How do you submit a paper claim?

When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription and submit a paper claim.

To submit a paper claim, send your claim and receipt to the following address:

Anthem Blue Cross MedicareRx
P.O. Box 145433 Cincinnati, OH 45250-5433

Upon receipt, we will make an initial coverage determination on the claim.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we should cover your prescription drugs. We will cover them as long as the drugs meet all coverage requirements (such as the drugs being on our formulary, filled at a network pharmacy, etc.) and they aren't covered by Medicare Part A or Part B. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements, including the requirement that the skilled nursing facility pharmacy be in our pharmacy network (unless you meet standards for out-of–network care) and that the drugs wouldn't otherwise be covered by Medicare Part B. When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this plan and join a new Medicare Advantage or Prescription Drug Plan.

Long-term care pharmacies

Generally, residents of a long-term-care facility (like a nursing home) may get their prescription drugs through the facility's long-term-care pharmacy or another network long-term-care pharmacy. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact customer service at the phone number on the cover of this booklet.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through this plan's pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies).

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact customer service.

Home infusion pharmacies

This plan will cover home infusion therapy if:

- your prescription drug is on this plan's formulary or a formulary exception has been granted for your prescription drug
- your prescription drug is not otherwise covered under Medicare Part B
- our plan has approved your prescription for home infusion therapy, and
- your prescription is written by an authorized prescriber

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, please contact customer service.

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

We may cover vaccines that are preventive in nature including the cost associated with administering the vaccine and aren’t already covered by Medicare Part B. This coverage includes the cost of vaccine administration. (Please see *Section 3*, “How does your enrollment in this plan affect coverage for drugs covered under Medicare Part A or Part B?” for more information.)

Section 3 Prescription drug benefits

Deductible

This is the amount that must be paid each year before we begin paying for part of your drug costs. After you meet the deductible, you will reach the initial coverage period. To see if your plan requires a deductible, look at the benefit summary located in the front of this booklet.

Initial coverage period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called coinsurance or a copayment. Your coinsurance or copayment will vary depending on the drug and where the prescription is filled.

Once your total drug costs reach $2,400, you will reach your initial coverage limit. Your initial coverage limit is calculated by adding payments made by this plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this plan, the amount they spend may count towards your initial coverage limit.

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. To find out which drugs this plan covers, refer to your formulary.

After your total drug costs reach $2,400 we will continue to provide prescription drug coverage until your total out-of-pocket costs reach $1,000. Once your total out-of-pocket costs reach $1,000 you will qualify for catastrophic coverage.

Catastrophic coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $1,000 out-of-pocket for the year. When the total amount you have paid toward your deductible, copayments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches $1,000 you will qualify for catastrophic coverage. During catastrophic coverage you will pay: $0 (zero) for covered generic and formulary brand name drugs.

Note: As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your deductible, initial coverage limit, or total out of pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for catastrophic coverage).

Vaccines (including administration)

Our plan's prescription drug benefit covers a number of vaccines including vaccine administration. The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from your doctor, who is not part of our pharmacy network, and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, and then you will be reimbursed. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under this plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

Vaccines are covered as an injectable drug under your prescription drug plan. Traditionally, injectable drugs are paid at either a coinsurance percentage or at a copay amount. Some plans pay all covered injectable drugs at the same copay or coinsurance, regardless of brand or generic status. For other plans, injectable drugs are paid at the generic or brand copayment, based on whether or not the drug is classified as generic or brand. Please check the benefit summary located in the front of this book to determine your vaccine benefit.

Remember you are responsible for all of the costs associated with vaccines including their administration during any deductible or coverage gap phases of your benefit, if applicable. Please check the benefits summary located in the front on this book to determine your vaccine benefit.

If you obtain the vaccine at	And get it administered by	You pay (and are reimbursed):
The Pharmacy	**The Pharmacy (not possible in all States)**	You pay your copay or co-insurance percentage indicated on your benefit summary in the front of this book.
Your Doctor	**Your Doctor**	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less the copay amount or coinsurance indicated on the benefit summary in the front of this book, plus any difference between the amount the doctor charges and what we normally pay. Or, if your doctor agrees to submit your claim on your behalf, you pay the copay amount or coinsurance indicated on the benefit summary in the front of this book, plus any difference between the amount the doctor charges and what we normally pay.*
The Pharmacy	**Your Doctor**	You pay the copay amount or coinsurance indicated on the benefit summary in the front of this book at the pharmacy, and the full amount charged by the doctor for administering the vaccine. You are reimbursed the latter amount less the copay amount or coinsurance indicated on the benefit summary in the front of this book, plus any difference between what the doctor charges for administering the vaccine and what we normally pay.*

* If you receive 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, the NDC code, the vaccine name and the amount charged. Send the bill to

Anthem Blue Cross MedicareRx
P.O. Box 145433
Cincinnati, OH 45250-5433

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.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs? The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- your annual deductible
- your coinsurance or copayments
- payments you make after the initial coverage limit

When you have spent a total of for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs will not count toward your out-of-pocket costs:

- prescription drugs purchased outside the United States and its territories
- prescription drugs not covered by this plan
- prescription drugs covered by Part A or Part B

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- family members or other individuals
- Qualified State Pharmacy Assistance Programs (SPAPs)
- Medicare programs that provide extra help with prescription drug coverage; and
- most charities or charitable organizations that pay cost-sharing on your behalf Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following **don't count** toward your out-of-pocket costs:

- group health plans
- insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- third party arrangements with a legal obligation to pay for prescription costs (e.g., workers compensation)

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside this plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail-order-pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under "Utilization Management."

The drugs on the formulary are selected by this plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active ingredient as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See *Section 6* for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See *Section 2* for more information about filling a prescription at an out-of network pharmacy.

How do you find out what drugs are on the formulary?

You may call customer service to find out if your drug is on the formulary or to request a copy of our formulary.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your cost-sharing depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See *Section 8* to learn more about how to request an exception.

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- adding or removing drugs from the formulary
- adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, add prior authorizations, quantity limits and/ or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60-day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to an appropriate drug that we cover or request a formulary exception before the change to the formulary takes effect. If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members taking the drug about the change as soon as possible.

What if your drug isn't on the formulary?

If your prescription isn't listed on the formulary, you should first contact customer service to be sure it isn't covered. Some plans cover drugs not on the formulary at a higher copay. Please check your benefits summary at the beginning of this Evidence of Coverage booklet to see if your plan covers non-formulary drugs. Or you can follow one of the three steps listed below.

If customer service confirms that we don't cover your drug, you have three options:

1. You may ask your doctor f you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact customer service.

2. You may ask us to make an exception (which is a type of coverage determination) to cover your drug. See *Section 8* to learn more about how to request an exception.
3. You can pay out-of-pocket for the drug and request that this plan reimburse you by requesting an exception (which is a type of coverage determination). This doesn't obligate this plan to reimburse you if the exception request isn't approved. If the exception isn't approved, you may appeal this plan's denial. See *Section 8* for more information on how to request an appeal.

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this plan, you may be able to get a temporary supply of a drug you were taking when you joined this plan if it isn't on our formulary.

Transition policy

New members in this plan may be taking drugs that aren't in our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. See *Section 8* (under "What is an exception?") to learn more about how to request an exception. Please contact customer service if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year, and you need help switching to an appropriate drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90-days of new membership in this plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year/provide you with the opportunity to request a formulary exception in advance for the following year.

For each of the drugs that isn't on our formulary or that has coverage restrictions or limits, we will cover a temporary 30-day supply (unless the prescription is written for fewer days) when a new or current member goes to a network pharmacy and the drug is otherwise a "Part D drug". After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 34-day transition supply unless you have a prescription written for

fewer days. If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in this plan, when that member is a resident of a long-term-care facility. If a new member, who is a resident of a long-term-care facility and has been enrolled in this plan for more than 90 days, needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and that are bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access.

Reimbursing plan members for coverage during retroactive periods

If you were automatically enrolled in this plan because you were Medicaid eligible, your enrollment in this plan may be retroactive back to when you became eligible for Medicaid. Your enrollment date may even have occurred during the prior year. In order to be reimbursed for expenses you incurred during this time period (and that were not reimbursed by other insurance), you must submit a paper claim to us (See "How do you submit a paper claim" in *Section 2*). We are required to have a seven month special transition period that allows us to cover most of your claims from the effective date of your enrollment to the current time; however, depending upon your situation, you or Medicare may be responsible for any out-of-network or price differentials. You may also be responsible for some claims outside of the seven-month special transition period if the claims are for drugs not on our formulary. For more information, please call customer service.

Drug management programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for this plan to help us provide quality coverage to our members.

The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that authorized prescribers will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.

- Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 4 tablets (35mg) or 30 tablets (5mg or 20mg) per prescription for Actonel.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your

doctor has told us that you must take the brand-name drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary document or by calling customer service. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See *Section 8* for more information about how to request an exception.

Drug utilization review

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

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

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this plan doesn't affect Medicare 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, it can't be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this plan (Medicare Part D) in other cases but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

See your *Medicare & You* handbook for more information about drugs that are covered by Medicare Part A and Part B.

Section 4 Your costs for this plan

Paying your monthly plan premium

If you get your benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your plan premium.

Note: If you are getting extra help with paying for your drug coverage, the premium amount that you pay as a member of this plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs". Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP to determine what benefits are available to you.

Can your premiums change during the year?

Generally, your plan premium can't change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1.

In certain cases, your plan premium may change during the calendar year. If you aren't currently getting extra help, but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or resources or if you get married or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. Social Security or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help (see contact information in *Section 1*).

Some Employer/Union groups renew their retiree benefits during the calendar year rather than on January 1st. At that time your premium and coverage may change.

Paying your share of the cost when you get covered drugs

What are "deductibles," "copayments," and "coinsurance"?

- The "deductible" is the amount you must pay for the drugs you receive before this plan begins to pay its share of your covered drugs. Please refer to the benefit summary at the front of this booklet see if your plan has a deductible.
- A "copayment" is a payment you make for your share of the cost of certain covered drugs you receive. A copayment is a set amount per drug. You pay it when you get the drug. Please refer to the benefit summary at the front of this booklet to see the copayments your plan may have.

- "Coinsurance" is a payment you make for your share of the cost of certain covered drugs you receive. Coinsurance is a percentage of the cost of the drug. You pay your coinsurance when you get the drug. Please refer to the benefit summary at the front of this booklet to see coinsurance your plan may have.

How much do you pay for drugs covered by this plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see "Do you qualify for extra help?" in *Section 1* of this booklet, and the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs."

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., deductible, initial coverage period, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below.

Using all of your insurance coverage

If you have additional prescription drug coverage besides this plan, it is important that you use your other coverage in combination with your coverage as a member of this plan to pay your prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the drug benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You are required to tell this plan if you have additional drug coverage.

Important Information about Medicare Prescription Drug Coverage

We will send you a Coordination of Benefits Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional drug coverage, you are required to provide that information to this plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional prescription drug coverage, please call customer service to update your membership records.

You must tell us if you have any other prescription drug coverage besides this plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage you might have include the following:

- coverage that you have from an employer's group health insurance for employees or retirees, either through yourself or your spouse
- coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program

- coverage you have for an accident where no-fault insurance or liability insurance is involved
- coverage you have through Medicaid
- coverage you have through the "TRICARE for Life" program (veteran's benefits)
- coverage you have for dental insurance
- coverage you have for prescription drugs
- continuation coverage that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and you go without creditable prescription drug coverage (as good as Medicare's) for 63 continuous days or more, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006 and/or 2007, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2007, the national base beneficiary premium is $27.35). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call customer service to find out more about the reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- you had creditable prescription drug coverage (as good as Medicare's)
- the period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- you prove that you were not informed that your prescription drug coverage was not creditable
- you lived in an area affected by Hurricane Katrina AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- you received or are receiving extra help AND you join a Medicare prescription drug plan by December 31, 2007, AND you stay in a Medicare prescription drug plan

Your late enrollment penalty may be reduced or eliminated if:

- you receive extra help in 2008 or after

Section 5 Your rights and responsibilities as a member of this plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of this plan and, we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "find a Medicare Publication." If you have any questions whether this plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with this plan, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. This plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call customer service at the phone number in *Section 1*. Customer service can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

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

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. *For example, you have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies)*. You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out

whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call customer service at the phone number in *Section 1* of this booklet. This plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

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

You have the right to timely access to your prescriptions at any network pharmacy.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage. A complaint can be called a grievance or a coverage determination depending on the situation. See *Section 8* for more information about complaints.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against this in the past. To get this information, call customer service.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call customer service at the number in *Section 1* of this booklet. You can also get free help and information from your SHIP (contact information for your SHIP in *Section 1* of this booklet). You can also visit www.medicare.gov on the Web to view or download the publication “Your Medicare Rights & Protections.” Under “Search Tools,” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

See the end of this Evidence of Coverage to locate the SHIP office in your area.

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

If you think you have been treated unfairly or your rights have not been respected, you may call customer service or:

- if you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights
- if you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP (contact information for your SHIP is in *Section 1* of this booklet)

Your right to get information about your drug coverage and costs

This EOC tells you what you have to pay for prescription drugs as a member of this plan. If you need more information, please call our customer service numbers in *Section 1*. You have the right to an explanation from us about any bills you may get for drugs not covered by this plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See *Section 8* for more information about filing an appeal. You also have the right to receive an explanation from us of any utilization-management requirements, such as step therapy or prior authorization that may apply to your plan. If you have any questions please call customer service.

Your right to get information about this plan and our network pharmacies

You have the right to get information from us about this plan. This includes information about our financial condition and about our network pharmacies. To get any of this information, call customer service at the phone number shown in *Section 1*.

Section 6 General exclusions

Introduction

The purpose of this section is to tell you about drugs that are "excluded," meaning they aren't normally covered by a Medicare Prescription Drug Plan.

If you get drugs that are excluded, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in *Section 8*).

Drug exclusions

A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B. Also, while a Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted.[1] If the use is not supported by one of these reference books (known as compendia), then the drug is considered a non-Part D drug and cannot be covered by this plan.

By law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Non-prescription drugs (or over-the-counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
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	

We offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. This plan covers Barbiturates and Benzodiazepines; drugs used for the symptomatic relief of cough and cold, prescription vitamins and mineral products and drugs for the treatment of sexual or erectile dysfunction. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs.

[1] These reference books are: (1) American Hospital Formulary Service Drug Information, (2) the DRUGDEX Information System, and (3) USPDI (or its successor}

Please refer to your formulary to find out which drugs we are offering additional coverage for or call customer service if you have any questions.

Section 7 How to file a grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for a coverage determination, or an appeal, as described in *Section 8* of this manual because grievances do not involve problems related to approving or paying for Part D benefits.

If we will not give you the drugs you want, you must follow the rules outlined in *Section 8*.

- What types of problems might lead to your filing a grievance?
- if you feel that you are being encouraged to leave (disenroll from) this plan
- problems with the service you receive from customer service
- problems with how long you have to wait in a network pharmacy
- waiting too long for prescriptions to be filled
- rude behavior by network pharmacists or other staff
- cleanliness or condition of network pharmacies
- if you disagree with our decision not to give you a “fast” decision or a “fast” appeal. We discuss these fast decisions and appeals in more detail in *Section 8*
- you believe our notices and other written materials are hard to understand
- we don’t give you a decision within the required time frame (on time)
- we don’t forward your case to the independent review entity if we do not give you a decision on time
- we don’t give you required notices

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.” In certain cases, you have the right to ask for a “fast grievance,” meaning we will answer your grievance within 24 hours. We discuss fast grievances in more detail in *Section 8*.

Filing a grievance with this plan

If you have a complaint, please call the phone number for **Part D Grievances** in *Section 1* of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this** the Anthem Blue Cross MedicareRx grievance procedure, You may provide your grievance to us in writing or use the Grievance Form if you wish. Also, a customer service representative can fill out the Grievance Form while you are on the telephone.

On the form, be sure to provide all pertinent documentation and information. Mail the Grievance Form to: Anthem Blue Cross MedicareRx, Grievance and Appeals Unit, PO Box 1975, Fond du Lac, WI 54936-1975. We will acknowledge receipt of the Grievance Form within 5 working days of receiving it. We will obtain medical records and review

the issue. We will inform you, in writing, of our decision within 30 days. If you disagree with our decision to not give you a “fast appeal”, or if we take an extension on our initial decision or appeal, you have the right to ask for a “fast grievance”. We will respond to your “fast grievance” in 24 hours. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization QIO, or both. If you file with the QIO, we must help the QIO resolve the complaint. See *Section 1* for more information about the QIO.

See the end of this Evidence of Coverage to locate the QIO office in your area.

How to file a quality of care complaint with the QIO

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. See *Section 1* for more information about how to file a quality of care complaint with the QIO.

See the end of this Evidence of Coverage to locate the QIO office in your area.

Section 8 What to do if you have complaints about your prescription drug benefits

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call customer service at the number in *Section 1* of this booklet.

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

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For more information about grievances, see *Section 7*.

A coverage determination is the first decision we make about covering the drug you are requesting. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you may contact us if you want to request a coverage determination. For more information about coverage determinations and exceptions, see the section “How to request a coverage determination” below.

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You cannot request an appeal if we have not issued a coverage determination. If we issue an unfavorable coverage determination, you may file an appeal called a “redetermination” if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section “The appeals process” below.

How to request a coverage determination

What is the purpose of this section?

This part of *Section 8* explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word “provide” in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What is a coverage determination?

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

The following are examples of coverage-determination requests:

- You ask us to pay for a prescription drug you have received. This is a request for a coverage determination about payment. You may call us at the phone number shown under Part D Coverage Determinations in *Section 1* of this booklet to ask for this type of decision.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You may call us at the phone number shown under Part D Coverage Determinations in *Section 1* of this booklet to ask for this type of decision. See "What is an exception?" below for more information about the exceptions process.
- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You may call us at the phone number shown under Part D Coverage Determinations in *Section 1* of this booklet to ask for this type of decision. See "What is an exception?" below for more information about the exceptions process.
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You may call us at the phone number shown under Part D Coverage Determinations in *Section 1* of this booklet to ask for this type of decision. See "What is an exception?" below for more information about the exceptions process.
- You ask us to pay you back for the cost of a drug you bought at an out-of network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by this plan. See "Filling Prescriptions Outside of Network" in *Section 2* for a description of these circumstances. You may call us at the phone number shown under Part D Coverage Determinations in *Section 1* of this booklet to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

What is an exception?

An exception is a type of coverage determination. You may ask us to make an exception to our coverage rules in a number of situations.

- You may ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan that covers those excluded drugs.
- You may ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you may ask us to waive the limit and cover more. See *Section 3* ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs."
- You may ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the coinsurance/copayment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan formulary or the drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the copayment or coinsurance amount we require you to pay for the drug.

Who may ask for a coverage determination?

You, your prescribing physician, or someone you name may ask us for a coverage determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. This statement must be sent to us at the address listed under **Part D Coverage Determinations** in *Section 1* of this booklet. To learn how to name your appointed representative, you may call customer service at the number in *Section 1* of this booklet.

You also have the right to have a lawyer 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.

Asking for a "standard" or "fast" coverage determination Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?

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

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

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should call, fax, or write us at the numbers or address listed under Part D Coverage Determinations in *Section 1* of this booklet. For requests outside of regular business hours, a recording will tell the caller how to leave a message. A customer service representative will contact the requestor to begin the process.

Asking for a fast decision

You, your doctor, or your appointed representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under Part D Coverage Determinations in *Section 1* of this booklet. For requests outside of regular business hours, a recording will tell the caller how to leave a message. A customer service representative will contact he requestor to begin the process. Be sure to ask for a "fast," "expedited," or "24-hour" review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard time frame.

What happens when you request a coverage determination?

1. For a standard coverage determination about a Part D drug that includes a request to pay you back for a Part D drug that you have already received.

   Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as dosage or quantity limits or step therapy requirements), we must give you our decision no later than 72 hours after we receive y our physician's "supporting statement" explaining why the drug you are asking for is medically necessary. If you have not received an answer from us within 72 hours after we receive your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

2. For a fast coverage determination about a Part D drug that you have not received.

   If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review – sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

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

What happens if we decide completely in your favor?

1. For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug that you have already received.

   We must give you the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must give you the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

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

   We must give you the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must give you the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If a coverage determination does not give you all that you requested, you have the right to appeal the decision. (See Appeal Level 1.)

The appeals process

This part of *Section 8* explains what you can do if you disagree with our coverage determination.

What kinds of decisions can be appealed?

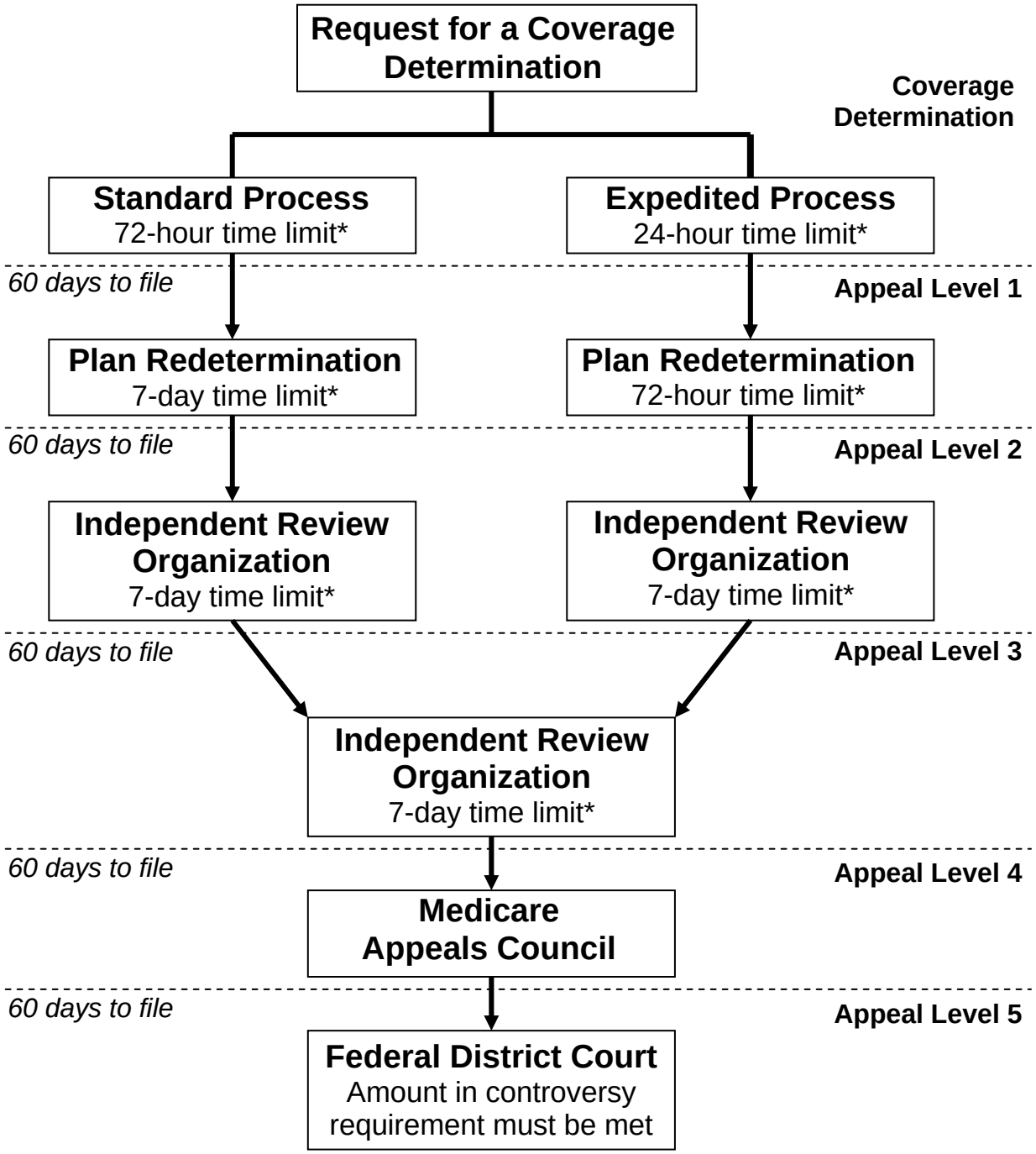
If you are not satisfied with our coverage determination decision, you may ask for an appeal called a “redetermination.” You may generally appeal the following decisions:

- we do not cover a Part D drug you think you are entitled to receive
- we do not pay you back for a Part D drug that you paid for
- we paid you less for a Part D drug than you think we should have paid you
- we ask you to pay a higher copayment amount than you think you are required to pay for a Part D drug, or
- we deny your exception request

How does the appeals process work?

There are five levels in the appeals process. At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may give you some or all of what you have asked for, or it may not give you anything you asked for. If you are unhappy with the decision, you may be able to appeal it and have someone else review your request.

The chart on the next page summarizes the appeals process. Each appeal level is discussed in greater detail following the chart.



* The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves an exception to the plan's formulary, the adjudication time frame begins when the plan sponsor or independent review organization receives the doctor's supporting statement.

Appeal Level 1:
If we deny any part of your request in our coverage determination, you may ask us to reconsider our decision. This is called a "request for redetermination."

You may ask us to review our coverage determination, even if only part of our decision is not what you requested. When we receive your request to review the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the coverage determination?

You or *your appointed representative* may file a **standard appeal** request.

You, your appointed representative, or *your doctor* may file a fast appeal request.

How soon must you file your appeal?
You must file the appeal request within **60 calendar days** from the date included on the notice of our coverage determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. **Asking for a standard appeal**

   To ask for a standard appeal, you or your appointed representative may send a written appeal request to the address listed under **Part D Appeals** in *Section 1* of this booklet. You may also ask for a standard appeal by calling us at the phone number shown under **Part D Appeals** in *Section 1* of this booklet.

2. **Asking for a fast appeal**

   If you are appealing a decision we made about giving you a Part D drug that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative may ask us for a fast appeal by *calling, faxing, or writing us at the numbers or address listed under* **Part D Appeals** in *Section 1* of this booklet. To request a review outside of regular business hours, you, your doctor, or appointed representative should call one of the customer service numbers listed on the cover or in *Section 1*. A recording will tell the caller how to leave a message. A customer service representative will contact the requestor to begin the process. Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal.

Getting information to support your appeal

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

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** in *Section 1* of this booklet. You may also deliver additional information in person to the address listed under **Part D Appeals** in *Section 1* of this booklet. You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** in *Section 1* of this booklet. We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on your appeal?

1. For a *standard* decision about a *Part D drug* that includes a request to pay you back for a Part *D drug you have already paid for and received*.

   We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to the second level of appeal, where an independent review organization will review your case.

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

   We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens if we decide completely in your favor?

1. For a standard decision to pay you back for a Part D drug you already paid for and received.

   We must send payment to you no later than 30 calendar days after we receive your appeal request.

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

   We must give you the Part D drug you asked for within seven calendar days we receive your appeal request. We will give it to you sooner if your health requires us to.

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

   We must give you the Part D drug you asked for within 72 hours after we receive your appeal request. We will give it to you sooner if your health requires us to.

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

What independent review organization does this review?

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

Who may file your appeal?

You or your appointed representative may file a standard or fast appeal request.

How soon must you file your appeal?

You must file the appeal request within *60 calendar days* after the date you were notified of the decision on your first appeal. The independent review organization may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. **Asking for a standard appeal**
   To ask for a standard appeal, you or your appointed representative can send a written appeal request to the independent review organization at the address included in the redetermination notice you receive from us.

2. **Asking for a fast appeal**
   To ask for a fast appeal, you or your appointed representative may send a written appeal request to the independent review organization at the address included in the redetermination notice you receive from us. Remember, if your doctor provides a written or oral statement supporting your request for a fast appeal, the independent review organization will automatically give you a fast appeal.

How soon must the independent review organization decide?

1. For a *standard* decision about a *Part D drug* that includes a request to pay you back for a *Part D drug that you have already paid for and received*.

   The independent review organization will give you its decision within seven calendar days after it receives your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves

an exception to this plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

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

   The independent review organization will give you its decision within 72 hours after it receives your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to this plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already paid for and received.

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

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

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

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

If the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge if the dollar value of the Part D drug you asked for meets the minimum requirement provided in the independent review organization's decision. During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

Who may file your appeal?
You or your appointed representative may file an appeal request with an Administrative Law Judge.

How soon must you file your appeal?
The appeal request must be filed within 60 calendar days of the date you were notified of the decision made by the independent review organization (Appeal Level 2). The Administrative Law Judge may give you more time if you have a good reason for missing the deadline.

How to file your appeal
The request must be filed with an Administrative Law Judge in writing. The written request must be sent to the Administrative Law Judge at the address listed in the decision you receive from the independent review organization (Appeal Level 2).

The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?
If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes:

- any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the plan year
- your copayments
- all drug expenses after your drug costs exceed the initial coverage limit, and
- payments for drugs made by other entities on your behalf

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;

2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;

3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and

4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon will the Judge make a decision?
The Administrative Law Judge will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:
The Administrative Law Judge will tell you in writing about his or her decision and the

reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 4:
If an ALJ does not rule in your favor, your case may be reviewed by the Medicare Appeals Council
If the Administrative Law Judge does not rule completely in your favor, you or your appointed representative may ask for a review by the Medicare Appeals Council.

Who may file your appeal?
You or your appointed representative may request an appeal with the Medicare Appeals Council.

How soon must you file your appeal?
The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Administrative Law Judge (Appeal Level 3). The Medicare Appeals Council may give you more time if you have a good reason for missing the deadline.

How to file your appeal
The request must be filed with the Medicare Appeals Council. The decision you receive from the Administrative Law Judge (Appeal Level 3) will tell you how to file this appeal.

How soon will the Council make a decision?
The Medicare Appeals Council will first decide whether to review your case (it does not review every case it receives). If the Medicare Appeals Council reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:
The Medicare Appeals Council will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.
   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 5:
If the Medicare Appeals council does not rule in your favor, your case may go to a Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- the decision is not completely favorable to you, or
- the decision tells you that the Medicare Appeals Council decided not to review your appeal request

Who may file your appeal?
You or your appointed representative may request an appeal with a Federal Court.

How soon must you file your appeal?
The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4).

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

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the Medicare Appeals Council's decision.

How soon will the Judge make a decision?
The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you within 30 calendar days after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

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

Section 9 Ending your membership

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

- you might leave this plan because you have decided that you want to leave
- there are also limited situations where we are required to end your membership; for example, if you move permanently out of our geographic service area

Voluntarily ending your membership

In general, there are only certain times during the year when you may voluntarily end your membership in this plan.

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1. Outside of this time period, you generally can't make other changes during the year unless you meet special exceptions, such as if you move, if you have Medicaid coverage, or if you get extra help in paying for your drugs. For more information about these times and the options available to you, please refer to the "Medicare & You" handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to learn more about your options.

In addition to the rules above, Employer/ Union Groups may allow changes to their retiree's enrollment at:

1. 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 from 11/15-12/31.
2. Please check with your prior employer for additional enrollment / disenrollment options and the impact of any changes to your employer/union sponsored retiree benefits.

Until your membership ends, you must keep getting your Medicare services through this plan or you will have to pay for them yourself.

Until your prescription drug coverage with this plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through this plan's network pharmacies.

We cannot ask you to leave this plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in this plan.

- If you move out of the service area or are away from the service area for more than 6 months in a row. If you plan to move or take a long trip, please call customer service to find out if the place you are moving to or traveling to is in this plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you cannot remain a member of this plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). However, in certain situations, employer groups are allowed to cover their out of state retirees under this plan.
- If you do not stay continuously enrolled in Medicare A or B (or both).
- If you intentionally provide false information on your enrollment request about other coverage you may have.
- If you behave in a way that is disruptive. We cannot make you leave this plan for this reason unless we get permission first from Medicare.
- You have the right to make a complaint if we end your membership in this plan.

If we end your membership in this plan we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

Section 10 Legal notices

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 applicable State(s) may apply.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin.` All organizations that provide Medicare Advantage Plans or Medicare Prescription Drug Plans, like this 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.

HIPAA Notice of Privacy Practices
Effective July 1, 2007

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. 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 and deductible payments. We may give information to a doctor's

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 also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, 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.

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/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.

They 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.

How we protect information

We are dedicated to protecting your PHI. We 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 offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The 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 non-affiliates 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. They 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 web site. We may also mail you a letter that tells you about any changes.

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.

State Notice of Privacy Practices
Effective July 1, 2007

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

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. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit. 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. 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.

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.

Section 11 Definitions of some words used in this book

Appeal - An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for a Part D drug benefit or payment for a Part D drug benefit you already received. There is a specific process that your Part D plan Sponsor must use when you ask for an appeal. *Section 8* explains what appeals are, including the process involved in making an appeal.

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

Catastrophic Coverage -The phase in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $1,000 in covered drugs during the covered year. Please see *Section 3* of this document.

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

Coverage Determination - A decision from your Medicare drug plan about whether a drug prescribed for you is covered by this plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs - The general term we use to mean all of the prescription drugs covered by this plan.

Creditable Prescription Drug Coverage - Prescription drug coverage (for example, from an employer or union) that is expected to pay as much as standard Medicare prescription drug coverage.

Deductible -The amount of money you must first pay for your drugs before the Plan will begin paying for your covered drugs.

Disenroll or Disenrollment - The process of ending your membership in this plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). *Section 9* discusses disenrollment.

Evidence of Coverage and Disclosure Information - This document, along with your enrollment form and any other attachments, 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 the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary - A list of covered drugs provided by the Plan.

Generic Drug - A prescription drug that has the same active ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Grievance - A type of complaint you make about us or one of this plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See *Section 7* for more information about grievances.

Initial Coverage Limit - The maximum limit of coverage under the initial coverage period.

Initial Coverage Period - This is the period after you have met your deductible (if you have one) and before your total drug expenses, have reached $2,400 including amounts you've paid and what this plan has paid on your behalf.

Late Enrollment Penalty - An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

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

Medicare Advantage Plan with Prescription Drug Coverage - A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. A Medicare Advantage Plan can be an HMO, PPO, or a Private Fee-for-Service Plan.

Medicare Health Plan - A Medicare Advantage Plan (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plans that are offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

“Medigap” (Medicare Supplement Insurance) Policy - Medicare supplement insurance policy sold by private insurance companies to fill “gaps” in the Original Medicare Plan. Medigap policies only work with the Original Medicare Plan.

Member (member of this plan) - 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).

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 this plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Out-of-Network Pharmacy - A pharmacy that doesn’t have a contract with this plan to coordinate or provide covered drugs to members of this plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by this plan unless certain conditions apply. See *Section 2*.

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

Part D Drugs - Drugs that Congress permitted this plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs, see your formulary for a specific list of covered drugs. Certain categories of drugs, such as benzodiazepines and barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see *Section 6* for a listing of these drugs). These drugs are not considered Part D drugs.

Prior Authorization - Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other plan provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

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

Service Area - A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a prescription drug sponsor.

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.

Section 12 State organizations contact information

State Health Insurance Assistance Program (SHIP)

Health Insurance Counseling and Advocacy
Program (HICAP) of California
1600 K Street
Sacramento, CA95814
1-800-434-0222

or

California Health Advocates
5380 Elvas Ave, Suite 104
Sacramento, CA 95819

Quality Improvement Organization

Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4447
415-677-2000

State Medicaid Offices

California Department of Health Services
P.O. Box 997413
Sacramento, CA 95899-7413
Local: 1-916-440-7400
or
Department of Human Services
2433 Marconi Ave
Sacramento, CA 95821-4807
1-916-875-3601

State Pharmacy Assistance Program

California Prescription Drug Discount
Program for Medicare Recipients
Medi-Cal
P.O. Box 997417
1501 Capitol Ave., Suite 71.5131
MS 4604
Sacramento, CA 95814
1-916-488-5298

State Office for Civil Rights

Office for Civil Rights, San Francisco Office
U.S. Department of Education
Old Federal Building
50 United Nations Plaza, Room 239
San Francisco, CA 94102-4912
(415) 556-4275; FAX# (415) 437-7783