Personal Choice® 65℠
A Blue Cross Medicare Advantage PPO Plan

Personal Choice 65 Part D Rider

An Addendum to Your Evidence of Coverage

Effective January 1, 2008
through December 31, 2008

1-888-718-3333
TTY/TDD: 1-888-857-4816
Seven days a week
8 a.m. — 8 p.m.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross—Independent licensees of the Blue Cross and Blue Shield Association.

USING NETWORK PHARMACIES TO GET YOUR PRESCRIPTION DRUGS COVERED BY US

What are network pharmacies?

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

- **What is a "network pharmacy"?** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drug. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. 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.
- **What are "covered drugs"?** The term "covered drugs" means all of the outpatient prescription drugs that are covered by our plan. Covered drugs are listed in our formulary.
- 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 directory or call Member Services to locate a retail pharmacy in our network at which you can obtain an extended supply of medications.

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 FutureScripts® Secure at **1-888-678-7015** 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 called "How do you submit a paper claim".

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy will 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 directory or call Member Services to find another network pharmacy in your area.

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

You may use our plan's mail-order service to fill prescriptions for any drug on the formulary list.

When you order prescription drugs through our network mail-order-pharmacy service, you must order a 90-day supply, and no more than a 90-day supply of the drug.

Generally, the mail-order pharmacy needs 14 days to process your order and ship it to you. However, your mail-order is sometimes delayed. If your mail-order has been delayed past the 14 days, please contact Caremark's Member Services at **1-866-236-6714,** Monday through Friday, 6 a.m. to 11 p.m., or Saturday and Sunday, 7 a.m to 11 p.m. If you need to obtain approval for a supply of your medication at a retail pharmacy in the Select Advantage network, please contact FutureScripts® Secure at **1-888-678-7015**. You may need to obtain a written prescription from your doctor.

You aren't required to use our mail-order services to get an extended supply of maintenance medications. You can also get an extended supply through retail network pharmacies.

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 our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances under which a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your prescription in these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription.** If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your copayment) when you fill your prescription. 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.

Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If the prescriptions are related to care for a medical emergency or urgent care.
- If you are unable to obtain a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- Some covered drugs that are administered in your doctor's office.

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. When you return home, simply submit a claim form and your receipt to the following address: FutureScripts Secure, P.O. 37694, Philadelphia, PA 19101-0694. Please call Member Services for more information on paper claims or to request a form. All claim forms must be submitted within six months of the date of service, unless Independence Blue Cross experienced claim problems that caused you to pay for your prescription in error.

If you submit a paper claim asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See page 14 to learn more about requesting coverage determinations.

In rare circumstances when you are in a coverage gap or deductible period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. Additionally, if you get help from and pay copayments under a drug manufacturer's patient assistance program that is outside our plan's benefit, you may submit documentation for the amount you paid and have it count towards qualifying you for catastrophic coverage. Please call Member Services for more information.

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, generally, our plan's medical benefit should 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 all coverage requirements are met (such as the drugs being on our formulary, prescriptions being filled at a network pharmacy, etc.) and they aren't covered by our plan's medical benefit. 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, but after our plan's medical benefit 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 our plan's medical benefit. 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. Please see Section 9 of the Evidence of Coverage book for more information about leaving this plan and joining a new Medicare 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 isn't, or for more information, please contact Member Services.

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 our 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 Member Services.

Home-infusion pharmacies

Our plan will cover home-infusion therapy if:

- Your prescription drug is on our plan's formulary or a formulary exception has been granted for your prescription drug.
- Your prescription drug is not otherwise covered under our plan's medical benefit.
- Our plan has approved your prescription for home infusion therapy.
- Your prescription is written by an authorized prescriber.
- You get your home infusion services from our plan's network pharmacy.

Note: We will cover only the cost of the prescription drugs and not the cost of other services and supplies associated with your home-infusion therapy, such as nursing services and supplies.

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

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 our plan's medical benefit. This coverage includes the cost of vaccine administration. (Please see page 8, "How does your enrollment in this plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

What is a formulary?

We have a formulary that lists all drugs that we cover. Generally, we will 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 our 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 coverage of certain types of drugs. (See "Drug Exclusions" later in this section for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In some cases, we have decided not to include a particular drug.

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

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

You may call Member Services to find out if your drug is on the formulary or to request a copy of our formulary. You may also get updated information about the drugs on our formulary by us by visiting our website at **www.site65.com**.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance/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 page 15 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 and quantity limits on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, or add prior authorizations and quantity limits 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 to 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 Member Services to be sure it isn't covered.

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

- You may ask your doctor if 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 Member Services or go to our formulary on our website (**www.site65.com**).
- You may ask us to make an exception (which is a type of coverage determination) to cover your drug. See page 15 to learn more about how to request an exception.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting an exception (which is a type of coverage determination). This doesn't obligate the plan to reimburse you if the exception request isn't approved. If the exception isn't approved, you may appeal the plan's denial. See page 17 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 our plan, even if that drug isn't on our formulary.

TRANSITION POLICY

New members in our plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization. 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 page 15 (under "What is an exception?") to learn more about how to request an exception. Please contact Member Services if your drug is not on our formulary, is subject to certain restrictions (such as a requirement for prior authorization or if the drug will not be on our formulary next year) and you need help switching to an appropriate drug that we cover or requesting a formulary exception.

While 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 our 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 to 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 again as part of our transition policy. 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 31-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 our 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 our plan for more than 90 days needs a drug that isn't on our formulary or is subject to other restrictions, such as dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

If a transition occurs due to a member changing setting, such as moving from home residence to a long-term care facility and then back again, Personal Choice 65 has a method in place to ensure that you have access to your medication. If your setting change cannot be identified by the automated system, the pharmacy can notify Personal Choice 65 of the setting change and provide you with your needed medications. You will receive notice that you must either switch to a therapeutically appropriate drug on the plan's formulary or request an exception to continue taking the requested drug.

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.

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 the cost of the drug plan. A team of doctors and/or pharmacists developed these requirements and limits for our 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 that 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 14 tablets per prescription for Ambien.

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 on our plan's formulary website or by calling Member Services. 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 page 15 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 any 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 will contact members who qualify for these programs. 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 use 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 they would never be covered by 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.

Depending on the Medicare coverage criteria there may be some variation in the cost-sharing applied to the drugs. You may contact our plan about different costs associated with drugs available in different settings and situations.

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

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?" later in this section, 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 your current coverage level (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.

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 our plan covers, refer to your formulary.

VACCINES (INCLUDING ADMINISTRATION)

Our plan's prescription drug benefit covers a number of vaccines (including vaccine administration). The amount for which you will be responsible 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 someone who is not part of our pharmacy network and that you may have to pay in advance for the entire cost of the vaccine and its administration. You will then need to mail us the receipts, in order

to be reimbursed. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

Remember that you are responsible for all costs associated with vaccines (including their administration) during any deductible or coverage gap phases of your 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 copayment/coinsurance
Your Doctor	**Your Doctor**	You may be asked to pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less copayment/coinsurance.
The Pharmacy	**Your Doctor**	You pay copayment/coinsurance at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the latter amount less copayment/coinsurance.*
Your Doctor obtains vaccines via the PBMs direct Ship program	**Your Doctor**	The direct Ship vendor bills you for applicable copay/coinsurance for the vaccine. You pay the full amount for the administration and are reimbursed by the plan and the full amount charged by the doctor for administering the vaccine. You are reimbursed the latter amount less copayment/coinsurance.

* If you receive extra help, we will reimburse you for this difference. Vaccine and administration costs will be fully reimbursed minus the member's copayment/coinsurance. Office visit fees will not be reimbursed through Medicare Part D Pharmacy benefits.

We can help you understand the costs associated with vaccines (including administration) available under our plan, especially before you go to your doctor. For more information, please contact Member Services.

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 meets our coverage requirements:

- Your annual deductible, if applicable.
- Your coinsurance or copayments.
- Payments you make after the initial coverage limit in the coverage gap.

When you have spent a total of $4,050 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 does not 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 the plan.
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make 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 do 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 do not 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).
- 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 part 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 the plan's benefit, you may submit documentation and have it count toward 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 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. 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. The amount of extra help you get will depend on your income and resources. You can qualify for extra help in one of two ways:

- **You automatically qualify for extra help and do not need to apply**. If you have full coverage from a state Medicaid program, receive help from Medicaid in paying your Medicare premiums (that is, you belong to a Medicare Savings Program), or receive 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.
- **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 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 you 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 mail you an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a member of our 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".

WHAT IF YOU BELIEVE YOU HAVE QUALIFIED FOR EXTRA HELP AND ARE PAYING TOO MUCH FOR YOUR COPAYMENT?

If you believe you have qualified for extra help and you are paying too much for your copayment amount when you get your prescription at a pharmacy, our plan has established a process that will allow you to provide evidence of your proper copayment level. To learn more about this process, call the Member Services number in Section 1 of the Evidence of Coverage book.

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 Member Services if you have questions.

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 our plan covers, refer to your formulary.

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 (that is, coverage that's as good as Medicare's) for 63 or more 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 that 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 Member 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 (that is, coverage that's 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.

DRUG EXCLUSIONS

A Medicare Prescription Drug Plan cannot 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 (that is, 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 cites 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 our plan.

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

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
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines
Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction	

We offer additional coverage of 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 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. Please refer to your formulary to find out which drugs we may be offering additional coverage, or call Member Services if you have any questions.

WHAT TO DO IF YOU HAVE COMPLAINTS ABOUT YOUR PART D 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 **Member Services** at the number in Section 1 of the Evidence of Coverage book.

Please NOTE: that this section addresses complaints about your Part D prescription drug benefits. If you have complaints about your medical benefits, you must follow the rules outlined in Section 9 of the Evidence of Coverage book.

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 of the Evidence of Coverage book.

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 the section 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 the Evidence of Coverage book 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 the Evidence of Coverage book 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, or quantity limits. 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 the Evidence of Coverage book 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 the Evidence of Coverage book 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 the Plan. See "Filling Prescriptions Outside of Network" on page 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 the Evidence of Coverage book 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 page 7 ("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 highest tier subject to the tiering exceptions process tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the lowest tier subject to the tiering exceptions process tier instead. This would lower the 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. Also, you may not ask us to provide a higher level of coverage for drugs that are in the tier designated as the high-cost tier.

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 and effective 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 the Evidence of Coverage book. To learn how to name your appointed representative, you may call Member Services at the number in Section 1 of the Evidence of Coverage book.

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 the Evidence of Coverage book.

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 the Evidence of Coverage book. 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) we must give you our decision no later than 72 hours after we receive your 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 the section explains what you can do if you disagree with our coverage determination.

WHAT KINDS OF DECISIONS CAN BE APPEALED?

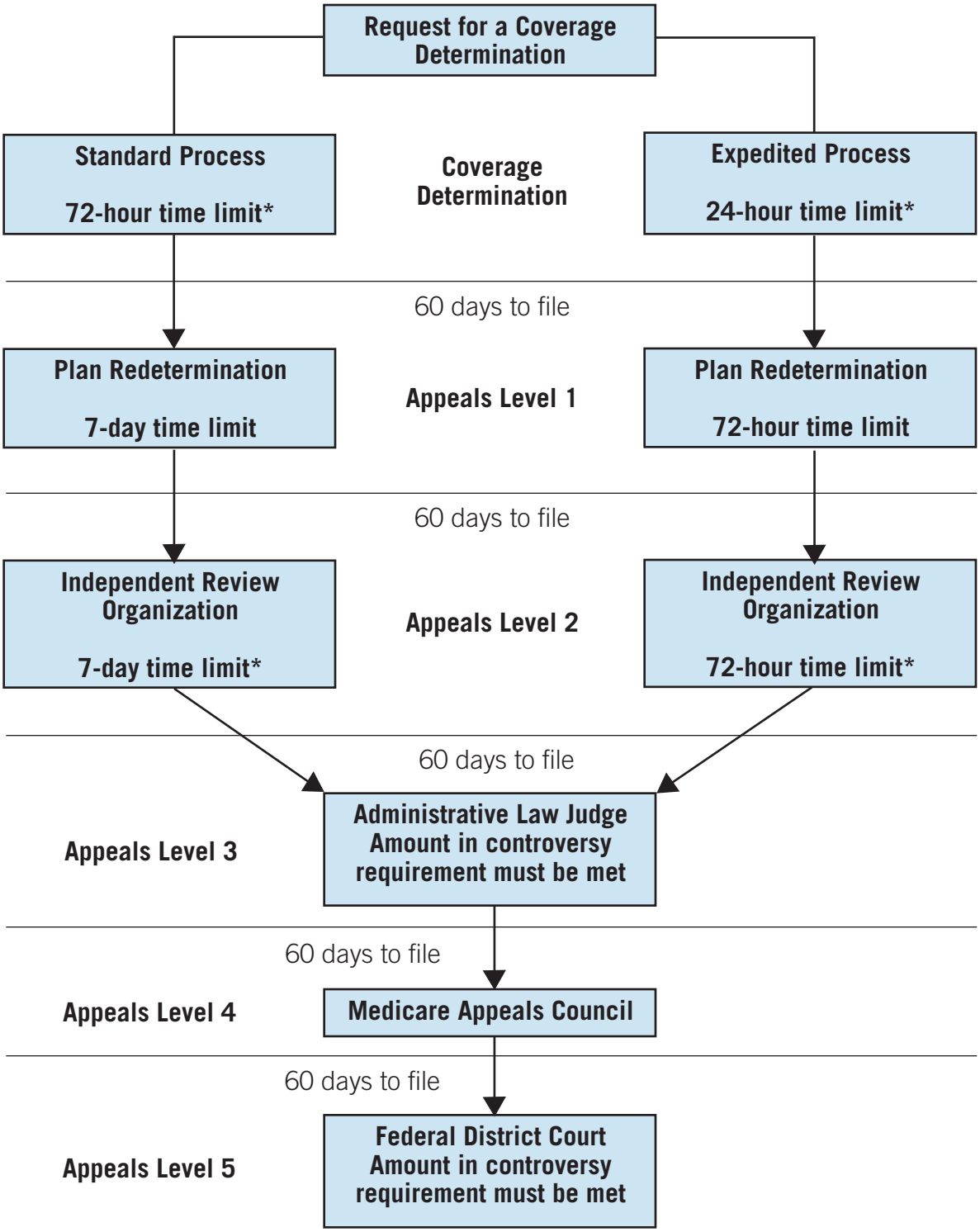
If you are not satisfied with our coverage determination decision, you may ask for an appeal called a "redetermination." You may generally appeal the following decisions:

- 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.
- 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 following chart summarizes the appeals process. Each appeal level is discussed in greater detail below.



*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 the Evidence of Coverage book. You may also ask for a standard appeal by calling us at the phone number shown under **Part D Appeals** in Section 1 of the Evidence of Coverage book.

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 the Evidence of Coverage book. 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 the Evidence of Coverage book. You may also deliver additional information in person to the address listed under **Part D Appeals** in Section 1 of the Evidence of Coverage book. 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 the Evidence of Coverage book.

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.

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 the 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 they receive 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 the 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.
- 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.
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.

NOTES

H3909
10680 2007-0377 (12/07)
PC2321 (01/08)