Medco Medicare Prescription Plan®

Commonwealth of Virginia
Retiree Health Benefits Program

Evidence of Coverage

Your Medicare prescription drug coverage as a member of *Medco Medicare Prescription Plan*® for the Commonwealth of Virginia Retiree Benefits Program

This document gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2009, and explains how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Medco Medicare Prescription Plan Customer Service:

For help or information, please call Customer Service or go to our plan website at **www.medco.com**.

Calls to this number are free:
1-800-572-4098

TTY/TDD users call: **1-800-716-3231**

Hours of Operation:
Our business hours are 24 hours a day, 7 days a week (except Thanksgiving and Christmas).
Customer Service is available in English and other languages.

This plan is offered by Medco Containment Life Insurance Company and Medco Containment Insurance Company of New York, referred to throughout the Evidence of Coverage as "we," "us," or "our." ***Medco Medicare Prescription Plan*** **is referred to as "Plan" or "our Plan." Our organization contracts with the Federal government.**

This information may be available in a different format, including Spanish and braille. Please call Customer Service at the numbers listed above if you need plan information in another format or language.

Esta información puede estar disponible en otros idiomas u otros formatos, incluyendo una versión en español y una versión en braille. Póngase en contacto con el departamento de Atención al cliente marcando los números que se indican arriba, si necesita recibir la información del plan en otro formato u otro idioma.

This Is Your 2009 Evidence of Coverage (EOC)

Table of Contents

1. Introduction 1

2. How You Get Prescription Drugs 7

3. Your Rights and Responsibilities as a Member of Our Plan 17

4. How to File a Grievance 21

5. Complaints and Appeals About Your Part D Prescription Drugs 23

6. Ending Your Membership 31

7. Definitions of Important Words Used in the EOC 35

8. Helpful Phone Numbers and Resources 39

9. Legal Notices 65

10. How Much You Pay for Your Part D Prescription Drugs — Your Plan Benefits 67

- *Excluded Drugs*

1. Introduction

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare drug coverage through our Plan, a Medicare prescription drug plan.

This Evidence of Coverage, together with your enrollment form, riders, formulary, and amendments that we send to you, is our contract with you. The Evidence of Coverage (EOC) explains your rights, benefits, and responsibilities as a member of our Plan, and is in effect from January 1, 2009 – December 31, 2009. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of this specific plan within the Commonwealth of Virginia Retiree Health Benefits Program beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

- What is covered by our 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 our Plan, and other Medicare options that are available, including your options for continuing Medicare prescription drug coverage

This section of the EOC has important information about:

- Eligibility requirements
- The geographic service area of our Plan
- Keeping your membership record up to date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty
- Extra help available from Medicare to help pay your plan costs

Eligibility requirements

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, or be enrolled in Medicare Part B, and be eligible to participate in the Commonwealth of Virginia Retiree Health Benefits Program. 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 remain a member of this Plan.

The geographic service area for our Plan

The states in our service area are listed below.

Alabama	Maine	Oregon
Alaska	Maryland	Pennsylvania
Arizona	Massachusetts	Rhode Island
Arkansas	Michigan	South Carolina
California	Minnesota	South Dakota
Colorado	Mississippi	Tennessee
Connecticut	Missouri	Texas
Delaware	Montana	Utah
Florida	Nebraska	Vermont
Georgia	Nevada	Virginia
Hawaii	New Hampshire	Washington
Idaho	New Jersey	West Virginia
Illinois	New Mexico	Wisconsin
Indiana	New York	Wyoming
Iowa	North Carolina	
Kansas	North Dakota	* District of Columbia
Kentucky	Ohio	* Puerto Rico
Louisiana	Oklahoma	

* The District of Columbia is a Federal district and Puerto Rico is a territory of the United States.

We offer coverage in all states and one territory.

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your eligibility record from the Commonwealth of Virginia Retiree Health Benefits Program, including your address and telephone number. Pharmacists and others use your membership record to know what drugs are covered for you. Section 3 tells how we protect the privacy of your personal health information. Please help us keep your membership record up to date by telling your Commonwealth of Virginia Benefits Administrator if there are changes to your name, address, or phone number. Also, respond to any requests from us regarding any changes in other health insurance coverage you have, such as from another employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership card

Now that you are a member of our Plan, you must use our membership card for prescription drug coverage at network pharmacies. You may need to continue to use your red, white, and blue Medicare card to get covered services and items under Original Medicare.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered prescription drugs. If your membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. There is a sample card in Section 10 to show you what it looks like.

The Pharmacy Directory gives you a list of plan network pharmacies

As a member of our 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, which can change during the year. You can also find this information on our website.

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. In addition to receiving your EOB in the mail, you may access your EOB by visiting our website. An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

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 that will occur at least 60 days in the future and affect the prescriptions you have gotten filled;
- A summary of your coverage this year, including information about:
  - **Annual Deductible** – (does not apply to generics) The amount you pay and/or others pay, before you begin the initial coverage period.
  - **Total Out-of-Pocket Costs That Count Toward Catastrophic Coverage** – The total amount you and/or others have spent on prescription drugs that count toward you qualifying for catastrophic coverage. This total includes the amounts spent for your deductible, coinsurance or co-payments. (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.)

Your monthly plan premium

The monthly premium amount described in this section does not include any late enrollment penalty you may be responsible for paying (see "What is the Medicare prescription drug plan late enrollment penalty?" later in this section for more information).

As a member of our Plan, you pay a monthly plan premium. (If you qualify for extra help from Medicare, called the Low-Income Subsidy, or LIS, you may not have to pay for part of the monthly premium.)

Your premium will be billed or deducted through the Commonwealth of Virginia Retiree Health Benefits Program as part of your total health benefits premium. The Commonwealth of Virginia will provide your annual benefit premium rates. If you have any questions about your Plan premiums, please contact your Commonwealth of Virginia Benefits Administrator.

Note: If you are receiving extra help with paying for your drug coverage, the amount by which your premium will be reduced is listed in your "**Evidence of Coverage Rider for Those Who Receive Extra Help Paying 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 at the phone numbers listed in Section 8 to determine what benefits are available to you.

Can your monthly plan premiums change during the year?

The monthly plan premium associated with this Plan cannot change during the year. However, the amount you pay could change, depending on whether you become eligible for, or lose, extra help for your prescription drug costs. The Commonwealth of Virginia Retiree Health Benefits Program will tell you in advance if there will be any changes for the next calendar year in your plan premium or in the amounts you have to pay when you get your prescriptions covered. If there are any changes for next year, they will take effect on January 1.

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/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is, and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualify for extra help, 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 2008, the national base beneficiary premium is $27.93. This amount may change in 2009). 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.

In most cases, the Commonwealth of Virginia Retiree Health Benefits Program eligibility policy will preclude the application of a late enrollment penalty. However, in limited cases where a penalty could apply (e.g., enrollment of a spouse without previous creditable coverage), the Commonwealth of Virginia Retiree Health Benefits Program will address the collection of penalty on an individual basis within their premium billing or deduction process. However, the penalty would generally apply under other (non-state program) Part D plans.

In general, under any Medicare Part D plan, you won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was <u>not</u> creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage that was less than 63 continuous days

- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005), 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

What happens if you don't pay or are late with your monthly plan premiums?

If you are billed for your monthly plan premiums (instead of having them deducted from a retirement benefit) and you are late with your payment, the Commonwealth of Virginia Retiree Health Benefits Program, through its billing agent, will tell you on your monthly invoice that your premium is past-due. As stated in your member handbook, monthly charges that remain unpaid 31 days from the date due will result in cancellation of your coverage. Once disenrolled, you may not re-enroll.

What extra help is available to help pay my plan costs?

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 any Medicare drug plan's monthly premium, yearly deductible, and prescription co-payments. 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 a letter to people who automatically qualify for extra help.
2. **You apply and qualify for extra help.** You may qualify if your yearly income in 2008 is less than $15,600 (single with no dependents) or $21,000 (married and living with your spouse with no dependents), and your resources are less than $11,990 (single) or $23,970 (married and living with your spouse). These resource amounts include $1,500 per person for burial expenses. 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 (TTY/TDD users should call 1-800-325-0778) or visit www.socialsecurity.gov on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. 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 2008 and will change in 2009. 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?

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 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 you believe that you are paying an incorrect co-payment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us. You will need to provide this documentation to us within the following timeframe: Documents must be provided to Medco no later than the last day of the second month from the time you were charged an incorrect co-payment amount. Once we receive supporting documentation, your level of extra help will be updated to reflect the correct information.

The acceptable forms of documentation are as follows:

- A copy of a member's Medicaid card, which includes the member's name and the eligibility date during the discrepant period;
- 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;
- 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 copy of a letter from the state or SSA showing Medicare Low-Income Subsidy status; or
- An award letter from the Social Security Administration confirming extra help eligibility during the discrepant period.

Proofs 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.

When we receive the evidence showing your co-payment level, we will update our system or implement other procedures so that you can pay the correct co-payment when you get your next prescription at the pharmacy. Please be assured that if you overpay your co-payment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy hasn't collected a co-payment from you and is carrying your co-payment 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.

Important Information

We will send you a Medicare questionnaire so that we can know what other drug coverage you have besides our 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 must provide that information to our 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.

2. How You Get Prescription Drugs

What do you pay for covered drugs?

The amount you pay for covered drugs is listed in Section 10.

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 cost-sharing. Please contact your SPAP to determine what benefits are available to you. SPAPs have different names in different states. See Section 8 for the name and phone numbers for the SPAP in your area.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of the 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, 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. Both brand-name drugs and generic drugs are included on the formulary. A generic drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Not all drugs are covered by our Plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 10 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 information later in this section about filling a prescription at an out-of-network pharmacy.

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

Each year, we send you an updated partial formulary so you can find out what drugs are on our formulary. You can get updated information about the drugs our Plan covers by visiting our website. You may also call Customer Service to find out if your drug is on the formulary, to request an updated copy of our partial formulary, or to request a complete formulary.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance or co-payment 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 5 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, or 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 a different drug that we cover or request an exception. (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 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 your copy of our formulary, you should first check the formulary on our website, which we update at least monthly (if there is a change). In addition, you may contact Customer Service to be sure it isn't covered. If Customer Service confirms that we don't cover your drug, you have two options:

1. 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 Customer Service or go to our formulary on our website.
2. You or your doctor may ask us to make an exception (a type of coverage determination) to cover your drug. If you pay out of pocket for the drug and request an exception that we approve, the Plan will reimburse you. If the exception isn't approved, you may appeal the plan's denial. See Section 5 for more information on how to request an exception or 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 if it 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 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 a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Section 5 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 for 2009 and you need help switching to a different 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 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.

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 34-day supply (unless the prescription is written for fewer days). After we cover the temporary 34-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 the prescription is 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. If the resident has been enrolled in our Plan for more than 90 days and 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 written 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 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. See Section 10 for information about non-Part D drugs.

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 our Plan to help us provide quality coverage to our members. Please consult your copy of our formulary or the formulary on our website for more information about these requirements and limits.

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 your provider will need to contact us before you fill your prescription. If we don't get the necessary information to satisfy the prior authorization, 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 34 tablets per 34-day period for a formulary drug.

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide you with the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request. Unless an exception is granted, you will have to pay 100% of the cost of the brand drug if it is not on our formulary.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or on our website, 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 5 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 prescribes 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. The "Medicare & You" handbook can also be found on www.medicare.gov, or you can request a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage (in addition to your Commonwealth of Virginia Retiree Health Benefits Program Medicare Supplemental 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 our 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 whether the prescription drug coverage you have is creditable (whether it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) 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 (in addition to your Commonwealth of Virginia Retiree Health Benefits Program Medicare Supplemental Coverage)

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact the other plan's benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you or your spouse are currently employed, the prescription drug coverage you get from us will be secondary to your employer group coverage.

Each year (prior to November 15), your other employer or retiree group should provide a disclosure notice to you that indicates if your prescription drug coverage is creditable (meaning it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and the options available to you. If the coverage is creditable, you should keep the disclosure notices that you get each year in your personal records to present to a Part D plan when you enroll to show that you have maintained creditable coverage. If you didn't get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer/union.

The coverage you have under our plan is a Medicare Part D plan, so we are not required to provide a notice of creditable coverage.

Using network pharmacies to get your prescription drugs

With few exceptions, which are noted later in this section under "How do you fill prescriptions outside the network?", **you must use network pharmacies to get your prescription drugs covered.** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You aren't required to always go 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 than the one you have previously used, 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. To find a network pharmacy in your area, please review your Pharmacy Directory. You can also visit our website or call Customer Service.

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 Directory or call Customer Service to find another network pharmacy in your area.

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 **1-800-922-1557** to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment), 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?"

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

You can use our network mail-order service to fill prescriptions for some drugs. The formulary list tells you which drugs are available through our mail-order service. When you order prescription drugs through our network mail-order pharmacy service, you may order up to a 90-day supply of the drug.

Generally, it takes the mail-order pharmacy 7 to 10 days to process your order and ship it to you. However, sometimes your mail order may be delayed. Make sure you have at least a 14-day supply of that medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a 30-day supply and fill it at a retail pharmacy while you wait for your mail-order supply to arrive. If your mail-order shipment is delayed, please call Customer Service at the numbers listed in Section 8. We'll make sure you have your medication when you need it.

You are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Instead, you have the option of using another retail network pharmacy in our network to obtain a supply of maintenance medications. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for an extended supply of maintenance medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may not agree to accept the mail-order cost-sharing amount for an extended supply of maintenance medications. In this case, you will be responsible for the difference in price. Your Pharmacy Directory contains information about retail pharmacies in our network at which you can obtain an extended supply of maintenance medications. You can also call Customer Service for more information.

To get order forms and information about filling your prescriptions by mail, either visit our website or call Customer Service at the numbers listed in Section 8. Please note that you must use our network mail-order service. Prescription drugs that you get through any other mail-order services are not covered.

How do you fill prescriptions outside the network?

Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when 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 Customer Service to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your coinsurance or co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You may pay more for a drug at an out-of-network pharmacy, but we will not pay more for a drug obtained at an out-of-network pharmacy than we would have paid at an in-network pharmacy.

You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. 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?"

In a medical emergency. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

When traveling away from our plan's service area. If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our mail-order pharmacy service. If you are traveling within the U.S. and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed in Section 8 to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

To obtain a covered drug in a timely manner. In some cases, you may be unable to obtain a covered drug in a timely manner within our service area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy.

If a network pharmacy does not stock a covered drug. Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible retail network pharmacy or through our mail-order pharmacy. We will cover prescriptions at an out-of-network pharmacy under these circumstances.

How do you submit a paper claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

Drugs purchased out of network. 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 in the section above ("How do you fill prescriptions outside the network?"), 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 us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

Drugs paid for in full when you don't have your membership card. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because you don't have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

Drugs paid for in full in other situations. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

Drugs purchased at a better cash price. In rare circumstances, when you are in a 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 a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage.

Co-payments for drugs provided under a drug manufacturer patient assistance program. If you get help from, and pay co-payments under, a drug manufacturer patient assistance program outside our plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage.

Vaccine costs (including their administration) that are obtained from an out-of-network provider. If you receive a vaccine out of network (from a physician, qualified provider, or pharmacist), you may submit a paper claim directly to the Part D plan to be reimbursed for your out-of-pocket cost. You are responsible for the co-payment applicable under your Plan.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. Although not required, you may use our reimbursement claim form to submit your written request. You can get a copy of our reimbursement claim form on our website or by calling Customer Service. **Please include your receipt(s) with your written request.**

Please send your written reimbursement request to the address listed under **Part D Reimbursement Requests** in Section 8.

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 will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our formulary, filled at a network pharmacy, 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 Part D 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 as part of a Medicare-covered skilled nursing facility stay, we will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our formulary, the skilled nursing facility pharmacy is in our pharmacy network, and the drugs aren't otherwise covered by Medicare Part A or 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 Medicare Advantage Plan, or a new prescription drug plan, or the Original Medicare Plan. See Section 6 for more information about leaving this Plan and joining a new Medicare plan.

Long-Term Care (LTC) pharmacies

Generally, residents of a long-term care facility (like a nursing home) may get their prescription drugs through the facility's LTC pharmacy or another network LTC pharmacy. Please refer to your Pharmacy Directory to find out if your LTC pharmacy is part of our network. If it isn't, or for more information, contact Customer Service.

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, contact Customer Service.

Home Infusion pharmacies

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

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

We may cover vaccines that are preventive in nature and aren't already covered by Medicare Part B. This coverage includes the cost of vaccine administration. See Section 10 for more information about your costs for covered vaccinations.

3. Your Rights and Responsibilities as a Member of Our 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 our Plan, and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

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. Our 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. Customer Service can also help if you need to file a complaint about access (such as wheelchair 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 we receive 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 to whom 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 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.

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. 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 the privacy of your personal information and medical records, please call Customer Service.

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

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone, such as a family member or friend, to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

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

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with your state's Department of Health.

Your right to get information about our Plan

You have the right to get information from us about **Medco Medicare Prescription Plan** for the Commonwealth of Virginia Retiree Benefits Program. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Customer Service.

Your right to get information in other formats

You have the right to get your questions answered. Our Plan must have individuals and translation services available to answer questions from non-English-speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of a disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

Your right to get information about our network pharmacies

You have the right to get information from us about our network pharmacies. To get this information, call Customer Service.

Your right to get information about your prescription drugs and costs

You have the right to an explanation from us about any prescription drugs not covered by our Plan. We must tell you in writing why we will not pay for, or approve, a prescription drug and how you can file an appeal to ask us to change this decision. See Section 5 for more information about filing an appeal. You also have the right to this explanation even if you obtain the prescription drug from a pharmacy not affiliated with our organization. You also have the right to receive an explanation from us about any utilization management requirements, such as step therapy or prior authorization, which may apply to your Plan. Please review our formulary website or call Customer Service for more information.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage. See Section 4 and Section 5 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 our Plan 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, you can:

1. Call Customer Service at the numbers on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 8 of this booklet.
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

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.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Customer Service if you have questions.
- Using all of your insurance coverage. If you have additional prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our 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.
- **Telling our Plan if you have additional drug coverage. Call Customer Service.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan, and you must present your plan membership card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions, and have them explain your treatment in a way you can understand.
- Paying your plan premiums and coinsurance or co-payments for your covered services. You must pay for services that aren't covered.
- Notifying your Commonwealth of Virginia Benefits Administrator if you move. If you move within our service area, we need to keep your membership record up to date. If you move outside of our plan service area, you cannot remain a member of our Plan.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service.

4. How to File a Grievance

What is a grievance?

A grievance is any complaint other than one that involves a request for an initial determination or an appeal, as described in Section 5 of this manual.

Grievances do not involve problems related to approving or paying for Part D drugs.

If we will not pay for or give you the Part D drugs you want, you must follow the rules outlined in Section 5.

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

- Problems with the service you receive from Customer Service.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- 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 Section 5.
- We don't give you a decision within the required timeframe.
- We don't give you required notices.
- You believe our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- We don't forward your case to the Independent Review Entity if we do not give you a decision on time.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance?

You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with state law to act for you. If you want someone to act for you who is not already authorized by the Court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone numbers for **Part D Grievances** (for complaints about Part D drugs) in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, 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 "**Medco Medicare Prescription Plan** Complaints and Grievances." If you prefer to state your grievance in writing, please send a grievance form or a letter with as much detail as possible to: Medco Medicare Prescription Plan, Medco Health Solutions, Inc., Attn: Service Grievance Resolution Team, P.O. Box 639405, Irving, TX 75063-9405. Medco automatically approves requests by the enrollee, or an enrollee's prescribing physician, on behalf of the enrollee, either orally or in writing, for expedited processing for initial determinations and redeterminations.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you ask for the extension, or if we justify a

need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast Grievances

In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 5.

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 the Quality Improvement Organization (QIO), or to both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone numbers of the QIO in your state.

5. Complaints and Appeals About Your Part D Prescription Drugs

Introduction

This section explains how you ask for coverage of your Part D drugs or payments in different situations. These types of requests and complaints are discussed below in Part 1.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1 are considered **grievances.** You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part D drugs. For more information about grievances, see Section 4.

PART 1. Requests for Part D drugs

This part explains what you can do if you have problems getting the Part D drugs you request or payment (including the amount you paid) for a Part D drug you already received.

If you have problems getting the Part D drugs you need or payment for a Part D drug you already received, you must request an initial determination with the Plan.

Initial determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug you need, or paying for a Part D drug you already received. Initial decisions about Part D drugs are called **"coverage determinations."** With this decision, we explain whether we will provide the Part D drug you are requesting or pay for the Part D drug you already received.

The following are examples of requests for initial determinations:

- You ask us to pay for a prescription drug you have received.
- 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." **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. **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." **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 "How do you fill prescriptions outside the network?" in Section 2 for a description of these circumstances.**

What is an exception?

An exception is a type of initial determination (also called a "coverage determination") involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- You may ask us to cover your Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan.

- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See Section 2 ("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 Part D drug. If your Part D drug is contained in our Tier 3, you may ask us to cover it at the cost-sharing amount that applies to drugs in our Tier 2 instead. This would lower the coinsurance or co-payment amount you must pay for your Part D drug. Please note, if we grant your request to cover a Part D 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 Part D drugs that are in our Tier 5.

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the plan formulary or the Part D drugs 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 Part D 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 Part D non-formulary drug, you cannot request an exception to the co-payment or coinsurance amount we require you to pay for the drug.

You may call us at the phone numbers shown under **Part D Coverage Determinations** in Section 8 to ask for any of these requests.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial 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 who is not already authorized under state law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed under **Part D Coverage Determinations** in Section 8. To learn how to name your appointed representative, you may call Customer Service.

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" initial determination

A decision about whether we will give you, or pay for, the Part D drug you are requesting can be a "standard" decision that is made within the standard timeframe, or it can be a "fast" decision that is made more quickly. A fast decision is also called an "expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug, you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) in Section 8.

Asking for a fast decision

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

If you are requesting a Part D drug that you have not yet received, you, your doctor, or your 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** (for appeals about Part D drugs) in Section 8.

Be sure to ask for a "fast," or "expedited," 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 decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a standard initial determination about a Part D drug (including 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 request is for a Part D drug that you have not received yet and your health condition requires us to. 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 prior authorization, dosage limits, quantity limits, or step therapy requirements), 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 (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a fast initial determination about a Part D drug that you have not yet received.

If we give you a fast review, we will give you our decision within 24 hours after you or your doctor asks for a fast review. We will give you the decision sooner if your health condition requires us to. 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 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 (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

We must cover 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 cover 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 (or supporting statement if your request involves an exception).

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

We must cover 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 cover 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 an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1.**)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the Plan about a Part D drug is also called a plan **"redetermination."** When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

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 initial 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 about a Part D drug, a signed, written appeal request must be sent to the address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

You may also ask for a standard appeal by calling us at the phone numbers shown under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

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 initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

Be sure to ask for a "fast," or "expedited," 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. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast appeal, we will give you a standard 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 or your representative. 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** (for appeals about Part D drugs) in Section 8.

You may also deliver additional information in person to the address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

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 numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

How soon must we decide on your appeal?

- 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 7 calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will automatically go to Appeal Level 2.

- For a fast decision about a Part D drug that you have not yet 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 condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

We must cover the Part D drug you requested as quickly as your health requires, but no later than 7 calendar days after we receive the request. 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.

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

We must cover the Part D drug you requested no later than 72 hours after we receive your request.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity.

How to file your appeal

If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the Plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the Plan had at Appeal Level 1.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- 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 decision.
- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part D drug you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ 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.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part D drug does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section **"Favorable decisions by the ALJ, MAC, or a Federal Court Judge"** below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC 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 MAC 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:

See the section **"Favorable decisions by the ALJ, MAC, or a Federal Court Judge"** below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: 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 MAC decided not to review your appeal request.

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 within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

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

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If he or she reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section **"Favorable decisions by the ALJ, MAC, or a Federal Court Judge"** below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- 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 decision.
- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

6. Ending Your Membership

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

- You might leave our 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 most Medicare Part D plans, there are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election Period"), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Outside of the state program, any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or those in the Commonwealth of Virginia Retiree Health Benefits Program, can make changes at other times. For more information on when you can make changes, see the enrollment period table at the end of this section. You may disenroll from **Medco Medicare Prescription Plan** for the Commonwealth of Virginia Retiree Health Benefits Program prospectively at any time; however, once disenrolled, you cannot re-enroll, so please be sure to check with Medicare on enrollment limitations associated with other (non-state-sponsored) plans.

During the fall open enrollment period, if you want to end your membership in our Plan, this is what you need to do:

- **If you are planning on joining another Medicare prescription drug plan:** Simply join the new Medicare prescription drug plan. You will be disenrolled automatically from our Plan when your new coverage begins on January 1.
- **If you are planning on enrolling in a Medicare Advantage Plan:** Request enrollment in the new plan. In most cases, you will be disenrolled automatically when your new plan's coverage begins on January 1. **NOTE: If you enroll in a Medicare Advantage Plan, benefits under your Commonwealth of Virginia Medicare supplemental plan may be excluded.**

EXCEPTION – If you are joining a Medicare Advantage "Private Fee-for-Service" Plan and that plan does not offer drug coverage, or a Medicare Medical Savings Account (MSA) Plan, enrollment will not automatically disenroll you from our Plan. Therefore, you will need to do the following:

  - To join a new Medicare prescription drug plan, simply join the new Medicare prescription drug plan, or
  - If you do not want Medicare prescription drug coverage, find out how to request disenrollment from our Plan by contacting Customer Service. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our Plan. TTY/TDD users should call 1-877-486-2048. You may also contact your Commonwealth of Virginia Benefits Administrator to request disenrollment from our plan.

- **If you would like to end your membership without joining any other Medicare health or prescription drug plan:** Contact Customer Service to find out how to request disenrollment. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our Plan. TTY/TDD users should call 1-877-486-2048. You may also contact your Commonwealth of Virginia Benefits Administrator to request disenrollment from our plan.

IMPORTANT – If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage (coverage that is at least as good as Medicare's drug coverage), you may have to pay a penalty if you join later.

Enrollment Period	When?	Effective Date
Fall open enrollment for Medicare Part D plans outside of the state program (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Medicare Advantage (MA) open enrollment MA-eligible beneficiaries can make one change to their health plan coverage. However you cannot use this period to add, drop, or change your Medicare prescription drug coverage. **Examples:** If you are in an MA Plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage Plan that does not offer drug coverage or go to Original Medicare. If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage. All Commonwealth of Virginia Retiree Health Benefits Program participants who are eligible for Medicare should be enrolled in the Original Medicare Plan in order to coordinate with the state program's supplemental coverage. If you are in an MA Plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan.	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request

Enrollment Period	When?	Effective Date
Special enrollment periods for limited special exceptions, such as: • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home) • You are in an Employer Group Waiver Medicare Part D plan such as the Commonwealth of Virginia Retiree Health Benefits Program and voluntarily disenroll	Determined by exception	Generally, first day of next month after plan receives your enrollment request

For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. Additional information can also be found in the "Medicare & You" handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from www.medicare.gov — under "Search Tools," select "Find a Medicare Publication."

Until you voluntarily or involuntarily disenroll, you must keep getting your Medicare prescription drug coverage through our Plan

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 our Plan.

Until your prescription drug coverage with our 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 our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy (including our mail-order pharmacy service), are listed on our formulary, and you follow other coverage rules.

We cannot ask you to leave the 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/TDD 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 our Plan:

- If you do not stay continuously enrolled in Medicare A or B (or both).
- If you move out of the service area or are away from the service area for more than 6 months, you cannot remain a member of our Plan, and we must end your membership ("disenroll" you).
- If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.

- If you do not pay the plan premiums, you will be notified by the Commonwealth of Virginia's billing agent that your premiums have not been paid. Premiums not paid within 31 days of their due date will result in cancellation of coverage.

You have the right to make a complaint if we end your membership in our Plan

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

7. Definitions of Important Words Used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for prescription drugs or payment for prescription drugs you already received. For example, you may ask for an appeal if our Plan doesn't pay for a drug you think you should be able to receive. Section 5 explains appeals, 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 drugs. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drugs has expired.

Catastrophic coverage – The phase in the Part D drug benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,350 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "co-payment" amounts that a plan may require be paid when specific drugs are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug.

Coverage determination – A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the 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 term we use to mean all of the prescription drugs covered by our Plan.

Creditable prescription drug coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Customer Service.

Deductible – The amount you must pay for the drugs you receive before our Plan begins to pay its share of your covered drugs. In our plan, this only applies to brand drugs.

Disenroll or **Disenrollment** – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 6 discusses disenrollment.

Evidence of Coverage (EOC) and disclosure information – This document, along with your enrollment record from the Commonwealth of Virginia and any other attachments or riders, explains your coverage, what we must do, your rights, and what you have to do as a member of our 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 is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

Initial coverage period – This is the period of coverage that begins each coverage year after you have met your deductible, if applicable, until you reach the catastrophic benefit level.

Late enrollment penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (hospital) and Part B (medical) benefits. An MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage organizations can offer one or more Medicare Advantage Plans in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) Plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with prescription drug coverage.** Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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

"Medigap" (Medicare Supplement Insurance) policy – Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage Plan is not a Medigap policy.)

Member (member of our Plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in our 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 our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare Plan ("Traditional Medicare" or "Fee-for-Service" Medicare) – The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance), and is available

everywhere in the United States. The Commonwealth of Virginia Retiree Health Benefits Program's Medicare-coordinating plans only work with the Original Medicare Plan.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – **See "Medicare Advantage (MA) Plan."**

Part D – The voluntary Medicare prescription drug benefit program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D drugs – Drugs that Congress permitted our 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, barbiturates, and over-the-counter drugs, were specifically excluded by Congress from the standard prescription drug package (see Section 10 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 network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare providers. See Section 8 for information about how to contact the QIO in your state and Section 4 for information about making complaints to the QIO.

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 – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

8. Helpful Phone Numbers and Resources

Contact information for our plan Customer Service

If you have any questions or concerns, please call or write to our plan Customer Service. We will be happy to help you.

CALL	**1-800-572-4098.** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week (except Thanksgiving and Christmas). Customer Service is available in English and other languages.
TTY/TDD	**1-800-716-3231.** This number requires special telephone equipment. Calls to this number are free.
WRITE	Medco Medicare Prescription Plan Medco Health Solutions, Inc. P.O. Box 630246 Irving, TX 75063-0115
VISIT	Medco Health Solutions, Inc. 8111 Royal Ridge Parkway Irving, TX 75063-2820
WEBSITE	**www.medco.com**

Contact information for coverage determinations, reimbursement requests, grievances, and appeals

Part D Coverage Determinations (about your Part D prescription drugs)

CALL	**1-800-753-2851.** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
TTY/TDD	**1-800-716-3231.** This number requires special telephone equipment. Calls to this number are free.
FAX	**1-888-235-8551**
WRITE	Medco Health Solutions, Inc. Attn: Medicare Reviews P.O. Box 630367 Irving, TX 75063-0118

For information about Part D coverage determinations, see Section 5.

Part D Reimbursement Requests (about your Part D prescription drugs)

CALL	**1-800-572-4098.** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week (except Thanksgiving and Christmas). Customer Service is available in English and other languages.
TTY/TDD	**1-800-716-3231.** This number requires special telephone equipment. Calls to this number are free.
WRITE	Medco Health Solutions, Inc. P.O. Box 14718 Lexington, KY 40512

Part D Grievances (about your Part D prescription drugs)

CALL	**1-800-572-4098.** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week (except Thanksgiving and Christmas). Customer Service is available in English and other languages.
TTY/TDD	**1-800-716-3231.** This number requires special telephone equipment. Calls to this number are free.
WRITE	Medco Medicare Prescription Plan Medco Health Solutions, Inc. Attn: Service Grievance Resolution Team P.O. Box 639405 Irving, TX 75063-9405

For information about Part D grievances, see Section 4.

Part D Appeals (about your Part D prescription drugs)

CALL	**1-800-753-2851.** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
TTY/TDD	**1-800-716-3231.** This number requires special telephone equipment. Calls to this number are free.
FAX	**1-888-235-8551**
WRITE	Medco Health Solutions, Inc. Attn: Medicare Reviews P.O. Box 630367 Irving, TX 75063-0118
VISIT	Medco Health Solutions, Inc. Attn: Medicare Reviews 8111 Royal Ridge Parkway Irving, TX 75063-2820

For information about Part D appeals, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your "Medicare & You" handbook, visit www.medicare.gov and choose "Find Helpful Phone Numbers and Websites," or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

State Health Insurance Assistance Program (SHIP)

A SHIP 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. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may find the contact information for your local SHIP at the end of this section. You may also find the website for your local SHIP at www.medicare.gov under "Search Tools" by selecting "Find Helpful Phone Numbers and Websites."

QIO or Quality Improvement Organization

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and 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 4 and 5 for more information about complaints, appeals, and grievances.

You may find the contact information for your local QIO at the end of this section.

How to contact the Medicare program

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

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Customer Service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare. This website gives you up-to-date information about Medicare and 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 "Find Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer.

Medicaid

Medicaid is a state government program that 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, contact your state's Medicaid office. Contact information for all state Medicaid offices can be found at the end of this section.

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/TDD users should call 1-800-325-0778. You may also visit www.ssa.gov on the Web.

State Pharmacy Assistance Program (SPAP)

SPAPs are state organizations that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact the SPAP in your state. You may find the contact information for the SPAP at the end of this section.

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/TDD users should call 1-312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "group") coverage (other than your Commonwealth of Virginia Retiree Health Benefits Program Coverage)

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse's current or former employer or union, call the employer's/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 enroll in Medicare Part D. Call your employer's/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.

Office for Civil Rights

Region I – CT, ME, MA, NH, RI, VT

Office for Civil Rights
U.S. Department of Health
& Human Services
J. F. Kennedy Federal Building
Room 1875
Boston, MA 02203
Telephone: 1-617-565-1340
TTY/TDD: 1-617-565-1343

Region II – NJ, NY, PR, VI

Office for Civil Rights
U.S. Department of Health
& Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, NY 10278
Telephone: 1-212-264-3313
TTY/TDD: 1-212-264-2355

Region III – DE, DC, MD, PA, VA, WV

Office for Civil Rights
U.S. Department of Health
& Human Services
150 S. Independence Mall West
Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111
Telephone: 1-215-861-4441
TTY/TDD: 1-215-861-4440

Region IV – AL, FL, GA, KY, MS, NC, SC, TN

Office for Civil Rights
U.S. Department of Health
& Human Services
Atlanta Federal Center
61 Forsyth Street, SW
Suite 3B70
Atlanta, GA 30303-8909
Telephone: 1-404-562-7886
TTY/TDD: 1-404-331-2867

Region V – IL, IN, MI, MN, OH, WI

Office for Civil Rights
U.S. Department of Health
& Human Services
233 N. Michigan Avenue
Suite 240
Chicago, IL 60601
Telephone: 1-312-886-2359
TTY/TDD: 1-312-353-5693

Region VI – AR, LA, NM, OK, TX

Office for Civil Rights
U.S. Department of Health
& Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Telephone: 1-214-767-4056
TTY/TDD: 1-214-767-8940

Region VII – IA, KS, MO, NE

Office for Civil Rights
U.S. Department of Health
& Human Services
601 East 12th Street
Room 248
Kansas City, MO 64106
Telephone: 1-816-426-7277
TTY/TDD: 1-816-426-7065

Region VIII – CO, MT, ND, SD, UT, WY

Office for Civil Rights
U.S. Department of Health
& Human Services
1961 Stout Street
Room 1426 FOB
Denver, CO 80294-2538
Telephone: 1-303-844-2024
TTY/TDD: 1-303-844-3439

Region IX – AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions

Office for Civil Rights
U.S. Department of Health
& Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Telephone: 1-415-437-8310
TTY/TDD: 1-415-437-8311

Region X – AK, ID, OR, WA

Office for Civil Rights
U.S. Department of Health
& Human Services
2201 Sixth Avenue
Mail Stop RX-11
Seattle, WA 98121
Telephone: 1-206-615-2290
TTY/TDD: 1-206-615-2296

Appendix I State Pharmacy Assistance Programs (SPAPs)

Alaska	**Alaska Senior Benefits Office** 855 W. Commercial Drive Wasilla, AK 99654	toll-free: 1-888-352-4150 local: 1-907-352-4150
Arizona	**Arizona CoppeRx Card** 801 E. Jefferson, MD-4100 Phoenix, AZ 85034	toll-free: 1-888-227-8315
Connecticut	**Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program (CONNPACE)** **Connecticut Department of Social Services** P.O. Box 5011 Hartford, CT 06102	toll-free: 1-800-423-5026 *(in-state calls only)* out-of-state: 1-860-269-2029
Delaware	**Delaware Prescription Assistance Program** **The Division of Social Services** P.O. Box 950 New Castle, DE 19720-9914	toll-free: 1-800-996-9969
Florida	**Florida Discount Drug Card** Enroll online: http://www.floridadiscountdrugcard.com/enrollment.aspx	toll-free: 1-866-341-8894 TTY/TDD: 1-866-763-9630
Hawaii	**Department of Human Services** Hawaii Rx Plus Program P.O. Box 700220 Kapolei, HI 96709-0220	local (Oahu): 1-808-693-7999 toll-free (neighbor islands): 1-866-878-9769
Illinois	**Illinois Cares RX** **Illinois Department on Aging** P.O. Box 19022 Springfield, IL 62794-9022	toll-free: 1-800-252-8966 TTY/TDD: 1-888-206-1327
Indiana	**HoosierRx** P.O. Box 6224 Indianapolis, IN 46206-6224	toll-free: 1-866-267-4679 local: 1-317-234-1381
Maine	**Maine Low Cost Drugs for the Elderly or Disabled (DEL) Program** **Office of MaineCare Services** 422 Civic Center Drive 11 State House Station Augusta, ME 04330	toll-free: 1-866-796-2463 TTY/TDD: 1-800-325-0778

Appendix I State Pharmacy Assistance Programs (SPAPs)

Maryland	**Maryland Senior Prescription Drug Assistance Program (SDPAP)** c/o Pool Administrators 100 Great Meadow Road Suite 705 Wethersfield, CT 06109	toll-free: 1-800-551-5995 TTY/TDD: 1-800-877-5156
Michigan	**Michigan's Prescription Drug Discount Card (MiRx)** P.O. Box 30412 Lansing, MI 48909	toll-free: 1-866-755-6479
Massachusetts	**Prescription Advantage Plan** P.O. Box 15153 Worcester, MA 01615-0153	toll-free: 1-800-243-4636 TTY/TDD: 1-677-610-0241
Missouri	**Missouri Rx Plan** P.O. Box 6500 205 Jefferson Street, 14th Floor Jefferson City, MO 65102-6500	toll-free: 1-800-375-1406
Montana	**Big Sky Rx Program** P.O. Box 202915 Helena, MT 59620-2915	toll-free: 1-866-369-1233 *(in-state calls only)* out-of-state & Helena: 1-406-444-1233
Nevada	**Nevada Senior Rx** **Department of Health & Human Resources** 4126 Technology Way, Suite 101 Carson City, NV 89706-2009	toll-free: 1-866-303-6323 local (Reno, Carson City, Gardnerville): 1-775-687-7555
New Jersey	**Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)** **Division of Senior Benefits and Utilization Management** **New Jersey Department of Health & Senior Services** P.O. Box 715 Trenton, NJ 08625-0715	toll-free: 1-800-792-9745
	Senior Gold **Division of Senior Benefits and Utilization Management** **New Jersey Department of Health & Senior Services** P.O. Box 724 Trenton, NJ 08625-0724	toll-free: 1-800-792-9745

Appendix I State Pharmacy Assistance Programs (SPAPs)

New York	**Elderly Pharmaceutical Insurance Coverage (EPIC)** P.O. Box 15018 Albany, NY 12212-5018	toll-free: 1-800-332-3742 TTY/TDD: 1-800-290-9138
North Carolina	**NCRx** P.O. Box 10068 Raleigh, NC 27690-2724	toll-free: 1-888-488-6279
Ohio	**Ohio's Best Rx** P.O. Box 408 Twinsburg, OH 44087-0408	toll-free: 1-866-923-7879 TTY/TDD: 1-866-763-9630
Oregon	**Senior Prescription Drug Assistance Program (SPDAP)** SPDAP Unit P.O. Box 14520 Salem, OR 97309-5044	toll-free: 1-877-877-7637 TTY/TDD: 1-800-735-1232
Pennsylvania	**PACE/PACENET Program** Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101	toll-free: 1-800-225-7223 local: 1-717-787-7313
South Carolina	**Gap Assistance Pharmacy Program for Seniors (GAPS)** **Department of Health and Human Services** P.O. Box 8206 Columbia, SC 29202	toll-free: 1-888-549-0820
Vermont	**VPharm, VHAP-Pharmacy, VScript, and Healthy Vermonters** Health Access Eligibility Unit 3 North 103 South Main Street Waterbury, VT 05671-1301	toll-free: 1-800-250-8427 TTY/TDD: 1-888-834-7898
Wisconsin	**Wisconsin SeniorCare** P.O. Box 6710 Madison, WI 53716-0710	toll-free: 1-800-657-2038

Appendix II State Health Insurance Assistance Programs (SHIPs)

Alabama	**Alabama Department of Senior Services** 770 Washington Avenue, RSA Plaza Suite 470 Montgomery, AL 36130-1851	toll-free: 1-800-243-5463 local: 1-334-242-5743 TTY/TDD: 1-334-242-0995
Alaska	**Alaska Medicare** **Senior Information Office** 3601 C Street, Suite 310 Anchorage, AK 99503-5209	toll-free: 1-800-478-6065 *(in-state calls only)* local: 1-907-269-3680 TTY/TDD: 1-907-269-3691
Arizona	**Arizona State Health Insurance Assistance Program** **Arizona Aging and Adult Administration** 1789 West Jefferson, Suite #950A Phoenix, AZ 85007	toll-free: 1-800-432-4040 TTY/TDD: 1-602-542-6366
Arkansas	**Senior Health Insurance Information Program** **Insurance Department** 1200 West Third Street Little Rock, AR 72201	toll-free: 1-800-224-6330 local: 1-501-371-2782
California	**Health Insurance Counseling and Advocacy Program (HICAP)** 1300 National Drive, Suite 200 Sacramento, CA 95814-1992	toll-free: 1-800-434-0222 *(in-state calls only)* local: 1-916-419-7500 TTY/TDD: 1-800-735-2929
Colorado	**Colorado Senior Health Insurance Assistance Program** 1560 Broadway, Suite 850 Denver, CO 80202	toll-free: 1-888-696-7213 local: 1-800-544-9181
Connecticut	**CHOICES** **Connecticut Department of Social Services** 25 Sigourney Street, 10th Floor Hartford, CT 06106	toll-free: 1-800-994-9422 *(in-state calls only)* local: 1-860-424-5274
Delaware	**ELDERinfo** **Delaware Insurance Department** Rodney Building 841 Silverlake Boulevard Dover, DE 19904	toll-free: 1-800-336-9500 *(in-state calls only)* local: 1-302-674-7364

Appendix II State Health Insurance Assistance Programs (SHIPs)

District of Columbia	**Washington, D.C. Health Insurance Counseling Program (HICAP)** 2136 Pennsylvania Avenue, NW Washington, D.C. 20052	local: 1-202-739-0668 TTY/TDD: 1-202-973-1079
Florida	**Florida Department of Elder Affairs** 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000	toll-free: 1-800-963-5337 local: 1-850-414-2060 TTY/TDD: 1-800-955-8771
Georgia	**GeorgiaCares** **Division of Aging Services** 2 Peachtree Street, NE, Suite 9385 Atlanta, GA 30303-3142	toll-free: 1-800-669-8387 local: 1-404-657-5334
Hawaii	**SAGE Plus** 250 South Hotel Street, 4th Floor Honolulu, HI 96813-2831	toll-free: 1-888-875-9229 local: 1-808-586-7299
Idaho	**Senior Health Insurance Benefits Advisors of Idaho (SHIBA)** 700 West State Street, Suite 406 Boise, ID 83720-0043	toll-free: 1-800-247-4422 *(in-state calls only)* local: 1-208-334-4350 TTY/TDD: 1-866-810-4379
Illinois	**Senior Health Insurance Program (SHIP)** 320 W. Washington Street Springfield, IL 62767-0001	toll-free: 1-800-548-9034 *(in-state calls only)* local: 1-217-785-9021 TTY/TDD: 1-217-524-4872
Indiana	**Indiana Health Insurance Assistance Information Program (SHIIP)** 714 West 53rd Street Anderson, IN 46013	toll-free: 1-800-452-4800 local: 1-317-233-3551
Iowa	**Senior Health Insurance Information Program (SHIIP)** 330 Maple Street Des Moines, IA 50319-0065	toll-free: 1-800-351-4664 local: 1-515-281-5705 TTY/TDD: 1-800-735-2942
Kansas	**Senior Health Insurance Counseling for Kansas (SHICK)** New England Building 503 S. Kansas Avenue Topeka, KS 66603	toll-free: 1-800-860-5260

Appendix II State Health Insurance Assistance Programs (SHIPs)

Kentucky	**State Health Insurance Program** **Kentucky Cabinet for Health Services** 275 E. Main Street, 5C-D Frankfort, KY 40621	toll-free: 1-877-293-7447
Louisiana	**Louisiana Senior Health Insurance Information Program** P.O Box 94214 Baton Rouge, LA 70804-9214	toll-free: 1-800-259-5301 *(in-state calls only)* local: 1-225-342-5301
Maine	**Maine Health Insurance Counseling Program** 11 State House Station Augusta, ME 04333	toll-free: 1-800-262-2232
Maryland	**Maryland Senior Health Insurance Assistance Program** 301 West Preston Street Baltimore, MD 21201	toll-free: 1-800-243-3425 *(in-state calls only)* local: 1-410-767-1100
Massachusetts	**Serving Health Information Needs of Elders (SHINE)** 1 Ashburton Place, 5th Floor Boston, MA 02108	toll-free: 1-800-243-4636
Michigan	**Michigan Medicare/Medicaid Assistance Program (MMAP)** 6105 W. St. Joseph Lansing, MI 48917-4850	toll-free: 1-800-803-7174 local: 1-517-886-1242
Minnesota	**Minnesota SHIP/Senior LinkAge Line** P.O. Box 64976 St. Paul, MN 55164-0976	toll-free: 1-800-333-2433 TTY/TDD: 1-800-627-3529
Mississippi	**Mississippi Insurance Counseling and Assistance Program (MICAP)** 750 North State Street Jackson, MS 39202	toll-free: 1-800-948-3090 local: 1-601-359-4929
Missouri	**CLAIM Program of Missouri** 200 North Keene Street Columbia, MO 65201	toll-free: 1-800-390-3330

Appendix II State Health Insurance Assistance Programs (SHIPs)

Montana	**State Health Insurance Counseling Program (SHIC)** 2030 11th Avenue Helena, MT 59620	toll-free: 1-800-551-3191 *(in-state calls only)* local: 1-406-444-7870
Nebraska	**Nebraska State Health Insurance Information** Terminal Building 941 O Street, Suite 400 Lincoln, NE 68508-3690	toll-free: 1-800-234-7119 local: 1-402-471-2201 TTY/TDD: 1-800-833-0920
Nevada	**State Health Insurance Assistance Program** 3100 W. Sahara Avenue, Suite 103 Las Vegas, NV 89102	toll-free: 1-800-307-4444 Las Vegas: 1-702-486-3478
New Hampshire	**HICEAS** **Health Insurance Counseling, Education, Assistance Service** 129 Pleasant Street Concord, NH 03301-3857	toll-free: 1-800-852-3388 *(in-state calls only)* local: 1-603-225-9000
New Jersey	**State Health Insurance Assistance Program** **New Jersey Department of Health and Senior Services** P.O. Box 360 Trenton, NJ 08625-0360	toll-free: 1-800-792-8820 *(in-state calls only)*
New Mexico	**Benefits Counseling Program** **New Mexico State Agency on Aging** 2550 Cerrillos Road Santa Fe, NM 87505	toll-free: 1-866-451-2901
New York	**Health Insurance Information and Counseling Assistance Program (HIICAP)** 2 Empire State Plaza Albany, NY 12223-1251	toll-free: 1-800-701-0501 local: 1-212-341-3978
North Carolina	**North Carolina Senior Health Insurance Information Program (SHIIP)** 111 Seaboard Avenue Raleigh, NC 27604	toll-free: 1-800-443-9354 local: 1-919-807-6900
North Dakota	**Senior Health Insurance Counseling** 600 East Boulevard Bismarck, ND 58505-0320	toll-free: 1-888-575-6611 local: 1-701-328-2440

Appendix II State Health Insurance Assistance Programs (SHIPs)

Ohio	**Ohio Senior Health Insurance Information Program (SHIP)** 50 W. Town Street, 3rd Floor Suite 300 Columbus, OH 43215	toll-free: 1-800-686-1578 local: 1-614-644-3458
Oklahoma	**Oklahoma Senior Health Insurance Counseling Program (SHICP)** P.O. Box 53408 Oklahoma City, OK 73107	toll-free: 1-800-763-2828 *(in-state calls only)* local: 1-405-521-6628
Oregon	**Oregon Senior Health Insurance Benefits Assistance (SHIBA)** 250 Church Street, SE Suite 200 Salem, OR 97301-3921	toll-free: 1-800-722-4134
Pennsylvania	**APPRISE** 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919	toll-free: 1-800-783-7067
Puerto Rico	**Puerto Rico Governor's Office of Elderly Affairs** Cobias Plaza Building UM Level Step 23 Ponce de Leon, PR 00902	toll-free (Bayamon): 1-800-981-1615 toll-free (Ponce): 1-800-981-7735 toll-free (San Juan): 1-877-725-4300
Rhode Island	**Rhode Island Senior Health Insurance Program (SHIP)** 160 Pine Street Providence, RI 02903-3708	local: 1-401-462-4000 TTY/TDD: 1-401-462-0740
South Carolina	**Insurance Counseling Assistance & Referrals for Elders (I-CARE)** **Lieutenant Governor's Office on Aging** 1301 Gervais Street, Suite 200 Columbia, SC 29201	toll-free: 1-800-868-9095 local: 1-803-734-9900
South Dakota	**Senior Health Information and Insurance Education (SHINE)** 2300 West 46th Street Sioux Falls, SD 57105	toll-free: 1-800-536-8197

Tennessee	**Tennessee Commission on Aging and Disability** 500 Deaderick Street, 8th Floor Nashville, TN 37243-0860	toll-free: 1-877-801-0044
Texas	**Health Insurance Information, Counseling, and Advocacy Program (HICAP)** P.O. Box 149030 Austin, TX 78714-9030	toll-free: 1-800-252-9240
Utah	**Health Insurance Information Program (HIIP)** **Aging and Adult Services of Utah** 120 North 200 West Street, Room 325 Salt Lake City, UT 84103	toll-free: 1-800-541-7735 *(in-state calls only)* local: 1-801-538-3910
Vermont	**(SHIP) Area Agency on Aging of Vermont** 1161 Portland Street St. Johnsbury, VT 05819	toll-free: 1-800-642-5119 *(in-state calls only)* local: 1-802-751-0428
Virginia	**Virginia Insurance Counseling and Assistance Program (VICAP)** **Virginia Department for the Aging** 1610 Forest Ave, Suite 100 Richmond, VA 23229	toll-free: 1-800-552-3402 Richmond: 1-804-662-9333
Washington	**Statewide Health Insurance Benefits Advisors** **Office of Insurance Commissioner** P.O. Box 40256 Olympia, WA 98504-0256	toll-free: 1-800-562-6900
West Virginia	**Bureau of Senior Services of West Virginia** 1900 Kanawha Boulevard, East Building #10 Charleston, WV 25305-0160	toll-free: 1-877-987-4463
Wisconsin	**Elderly Benefits Specialists** 1 West Wilson Street, Room 450 P.O. Box 7850 Madison, WI 53703-2118	toll-free: 1-800-242-1060 local: 1-608-246-7017
Wyoming	**Wyoming State Health Assistance Program (WYSIHP)** P.O. Box 30 Riverton, WY 82501	toll-free: 1-800-856-4398 local: 1-307-777-7401

Appendix III State Medicaid Offices

Alabama	**Alabama Medicaid Agency** 501 Dexter Avenue P.O. Box 5624 Montgomery, AL 36103-5624	local: 1-334-242-5000 toll-free: 1-800-362-1504
Alaska	**Alaska Department of Health and Social Services** Health Care Services Medicaid & Health Care Policy 4501 Business Park Blvd, Suite 24 Anchorage, AK 99503-7167	toll-free: 1-800-780-9972
Arizona	**Arizona Health Care Cost Containment System** 801 E. Jefferson Phoeniz, AZ 85034	local: 1-602-417-4000 toll-free: 1-800-654-8713 *(outside Maricopa County)* toll-free: 1-800-523-0231 *(within Maricopa County)* TTY/TDD: 1-602-417-4191
Arkansas	**Department of Human Services** P.O. Box 1437, Slot S401 Little Rock, AR 72203	local: 1-501-682-8740 toll-free: 1-800-482-5431 TTY/TDD: 1-501-682-6789
California	**California Department of Health Services** 1501 Capitol Avenue Sacramento, CA 95814	toll-free: 1-800-541-5555 TTY/TDD: 1-866-784-2595
Colorado	**Department of Health Care Policy and Financing of Colorado** 1570 Grant Street Denver, CO 80203-1818	local: 1-303-866-3513 toll-free: 1-800-359-1991 TTY/TDD: 1-800-659-2656
Connecticut	**Department of Social Services** 25 Sigourney Street Hartford, CT 06106-5033	local: 1-860-424-5116 toll-free: 1-800-842-1508 *(in-state calls only)* TTY/TDD: 1-800-842-4524
District of Columbia	**Department of Health** 825 North Capitol Street NE 5th Floor Washington, DC 20002	local: 1-202-442-5988

Appendix III State Medicaid Offices

Delaware	**Delaware Health and Social Services** **Division of Medicaid and Medical Assistance** Lewis Building Herman Holloway Sr. Campus 1901 N. Dupont Highway New Castle, DE 19720	local: 1-302-255-9500 toll-free: 1-800-996-9969
Florida	**Agency for Health Care** **Administration of Florida** 2727 Mahan Drive Tallahassee, FL 32308	local: 1-850-488-3560 toll-free: 1-888-367-6554
Georgia	**Georgia Department of Community Health** 2 Peachtree Street Atlanta, GA 30303	local: 1-770-570-3373 toll-free: 1-866-211-0950
Hawaii	**Department of Human Services of Hawaii** **State of Hawaii, Department of Human Services** Med-Quest Division 601 Kamokila Blvd., Room 518 Kapolei, HI 96707	local: 1-808-586-5390 TTY/TDD: 1-808-692-7182
Idaho	**Idaho Department of Health and Welfare** 3232 Elder Street Boise, ID 83705	local: 1-208-334-5747 toll-free: 1-877-200-5441 TTY/TDD: 1-208-332-7205
Illinois	**Illinois Department of Public Aid** 100 South Grand Avenue East, 3rd Floor Springfield, IL 62763-0001	local: 1-217-557-1601 toll-free: 1-800-843-6154 TTY/TDD: 1-800-447-6404
Indiana	**Office of Medicaid Policy and Planning** 402 W. Washington Street, Room W382 Indianapolis, IN 46204-2739	local: 1-317-233-8800
Iowa	**Department of Human Services of Iowa** P.O. Box 36510 Des Moines, IA 50315	local: 1-515-725-1003 toll-free: 1-800-338-8366
Kansas	**Kansas Health Policy Authority** Room 900-N, London State Office Building 900 SW Jackson Avenue Topeka, KS 66612	local: 1-785-296-3981 toll-free: 1-800-766-9012 TTY/TDD: 1-800-792-4292

Appendix III State Medicaid Offices

Kentucky	**Department of Medicaid Services** 275 East Main Street Frankfort, KY 40621	local: 1-502-564-4321 toll-free: 1-800-635-2570
Louisiana	**Louisiana Department of Health and Hospitals** 628 North 4th Street P.O. Box 91030 Baton Rouge, LA 70821-9030	local: 1-225-342-3893 toll-free: 1-888-342-6207 *(in-state calls only)* TTY/TDD: 1-225-216-7387
Maine	**Office of MaineCare Services** 11 State House Station Augusta, ME 04333-0011	local: 1-207-287-2093 toll-free: 1-800-977-6740 TTY/TDD: 1-800-977-6741
Maryland	**Department of Health and Mental Hygiene** 201 West Preston Street Baltimore, MD 21201	local: 1-410-767-5800 toll-free: 1-800-492-5231 TTY/TDD: 1-800-735-2258
Massachusetts	**Office of Medicaid** 1 Ashburton Place, 11th Floor, Room 1109 Boston, MA 02108	local: 1-617-573-1770 toll-free: 1-800-325-5231 TTY/TDD: 1-800-841-2900
Michigan	**Michigan Department of Community Health** Capitol View Building 201 Townsend Street Lansing, MI 48913	local: 1-517-373-3740 toll-free: 1-800-642-3195 *(in-state calls only)* TTY/TDD: 1-800-649-3777
Minnesota	**Department of Human Services of Minnesota** P.O. Box 64489 St. Paul, MN 55164-0989	local: 1-651-431-2670 toll-free: 1-800-657-3739 TTY/TDD: 1-800-627-3529
Mississippi	**Mississippi Division of Medicaid** Sillers Building 550 High Street, Suite 1000 Jackson, MS 39201-1399	local: 1-601-359-6050 toll-free: 1-800-421-2408 TTY/TDD: 1-800-855-1000
Missouri	**Department of Social Services of Missouri** 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500	local: 1-573-751-3425 toll-free: 1-800-392-2161 *(in-state calls only)* TTY/TDD: 1-800-735-2966

Montana	**Montana Department of Public Health & Human Services** P.O. Box 202951 Helena, MT 59620-2951	local: 1-406-444-4084 toll-free: 1-800-362-8312 *(in-state calls only)*
Nebraska	**Nebraska Department of Health and Human Services** P.O. Box 95044 301 Centennial Mall South Lincoln, NE 68509-5044	local: 1-402-471-3121 toll-free: 1-800-430-3244 TTY/TDD: 1-402-471-9570
New Hampshire	**New Hampshire Department of Health and Human Services** 129 Pleasant Street Concord, NH 03301-6521	local: 1-603-271-5254 toll-free: 1-800-852-3345 *(in-state calls only)* TTY/TDD: 1-800-735-2964
New Jersey	**Division of Medicaid Assistance and Health Services** Quakerbridge Plaza P.O. Box 712 Trenton, NJ 08625-0712	local: 1-609-588-2600 toll-free: 1-800-356-1561 *(in-state calls only)* TTY/TDD: 1-800-852-7899
New Mexico	**Department of Human Services of New Mexico** P.O. Box 2348 Sante Fe, NM 87504-2348	local: 1-505-827-3106 toll-free: 1-888-997-2583 TTY/TDD: 1-505-827-3184
Nevada	**Nevada Department of Human Resources, Aging Division** 1100 East William Street, Suite 101 Carson City, NV 89710	local: 1-775-684-3600 Las Vegas area: 1-702-486-9057 toll-free: 1-800-992-0900 *(in-state calls only)*
New York	**New York State Department of Health** Corning Tower, Room 2001 Empire State Plaza Albany, NY 12237-009	local: 1-518-474-3018 toll-free: 1-800-541-2831
North Carolina	**North Carolina Department of Health and Human Services Division of Medical Assistance** 2501 Mail Service Center 1985 Umstead Drive Raleigh, NC 27699-2517	Raleigh area: 1-919-855-4400 toll-free: 1-800-662-7030 *(in-state calls only)* TTY/TDD: 1-877-452-2514

Appendix III State Medicaid Offices

North Dakota	**Department of Human Services of North Dakota - Medical Services** 600 E. Boulevard Avenue, Department 325 Bismarck, ND 58505-0250	local: 1-701-328-2321 toll-free: 1-800-755-2604
Ohio	**Department of Job and Family Services of Ohio - Ohio Health Plans** 30 East Broad Street, 31st Floor Columbus, OH 43215-3414	local: 1-614-644-0140 toll-free: 1-800-324-8680 TTY/TDD: 1-800-292-3572
Oklahoma	**Health Care Authority of Oklahoma** 4545 N. Lincoln Boulevard Suite 124 Oklahoma City, OK 73105	local: 1-405-522-7171 toll-free: 1-800-522-0310 TTY/TDD: 1-405-522-7179
Oregon	**Office of Medical Assistance Programs** 500 NE Summer Street, 3rd Floor Salem, OR 97301-1079	local: 1-503-945-5772 toll-free: 1-800-527-5772 *(in-state calls only)* TTY/TDD: 1-800-375-2863
Pennsylvania	**Department of Public Welfare of Pennsylvania** Health and Welfare Building, Room 515 P.O. Box 2675 Harrisburg, PA 17105	local: 1-717-787-1870 toll-free: 1-800-692-7462 TTY/TDD: 1-800-451-5886
Puerto Rico	**Medicaid Office of Puerto Rico and Virgin Islands** GPO Box 70184 San Juan, PR 00936	local: 1-787-282-8298 toll-free: 1-877-725-4300
Rhode Island	**Department of Human Services of Rhode Island** 600 New London Avenue Cranston, RI 02920	local: 1-401-462-5300 TTY/TDD: 1-401-462-3363
South Carolina	**South Carolina Department of Health and Human Services** P.O. Box 8206 1801 Main Street Columbia, SC 29202-8206	toll-free: 1-888-549-0820

Appendix III State Medicaid Offices

South Dakota	**Department of Social Services of South Dakota** 700 Governors Drive Richard F. Kneip Building Pierre, SD 57501-2291	local: 1-605-773-3495
Tennessee	**Bureau of TennCare** 301 Great Circle Road Nashville, TN 37243	local: 1-615-507-6000 toll-free: 1-866-311-4287
Texas	**Health and Human Services Commission of Texas** Office of the Ombudsman MC H-700 P.O. Box 85200 Austin, TX 78708-5200	toll-free: 1-877-541-7905 TTY/TDD: 1-512-424-6597
Utah	**Utah Department of Health** P.O. Box 143106 Salt Lake City, UT 84114-3106	local: 1-801-538-6155 toll-free: 1-800-662-9651
Virginia	**Department of Medical Assistance Services** 7 North Eighth Street Richmond, VA 23219	local: 1-804-786-7933 toll-free: 1-800-552-8627 *(in-state calls only)*
Vermont	**Agency of Human Services of Vermont** 312 Hurricane Lane, Suite 201 Williston, VT 05495	local: 1-802-879-5901 toll-free: 1-800-250-8427 *(in-state calls only)* TTY/TDD: 1-802-241-1282
Washington	**Department of Social and Health Services of Washington** P.O. Box 45505 Olympia, WA 98504-5505	local: 1-360-725-1867 toll-free: 1-800-562-3022 *(in-state calls only)*
West Virginia	**West Virginia Department of Health & Human Resources** Bureau for Medical Services Office of Medicaid Managed Care Room 251 350 Capitol Street Charleston, WV 25301-3708	local: 1-304-558-1700

Wisconsin	**Wisconsin Department of Health and Family Services** 1 West Wilson Street, Room 350 P.O. Box 309 Madison, WI 53701-0309	toll-free: 1-800-362-3002 TTY/TDD: 1-608-267-7371
Wyoming	**Wyoming Department of Health Office of Healthcare Financing** 6101 Yellowstone Road Suite 210 Cheyenne, WY 82002	local: 1-307-777-7531

Appendix IV Quality Improvement Organizations (QIOs)

Alabama	**Alabama Quality Assurance Foundation** 2 Perimeter Park Drive, Suite 200 W Birmingham, AL 35243-2337	local: 1-205-970-1600 toll-free: 1-800-760-4550
Alaska	**Qualis** 741 Sesame Street, Suite 110 Anchorage, AK 99503	local: 1-907-562-5645 toll-free: 1-877-200-9046
Arizona	**Health Services Advisory Group** 1600 East Northern Avenue, Suite 100 Phoenix, AZ 85020	local: 1-602-264-6382 toll-free: 1-800-359-9909
Arkansas	**Arkansas Foundation for Medical Care** 401 West Capital Little Rock, AR 72201	local: 1-501-212-8600 toll-free: 1-800-272-5528
California	**Lumetra** One Sansome Street San Francisco, CA 94104	local: 1-415-677-2000 toll-free: 1-800-841-1602 TTY/TDD: 1-800-881-5980
Colorado	**Colorado Foundation for Medical Care** 23 Inverness Way East, Suite 100 Englewood, CO 80112-5708	local: 1-303-695-3300 toll-free: 1-800-950-8250
Connecticut	**Qualidigm** 100 Roscommon Drive Middletown, CT 06457	local: 1-860-632-2008 toll-free: 1-800-553-7590
Delaware	**Quality Insights of Delaware** Baynard Building, Suite 100 3411 Silverside Road Wilmington, DE 19810-4812	local: 1-302-478-3600 toll-free: 1-866-475-9669
District of Columbia	**Delmarva Foundation for Medical Care** 2175 K Street, NW, Suite 250 Washington, DC 20037	local: 1-202-293-9650 toll-free: 1-800-937-3362
Florida	**Florida Medical Quality Assurance** 5201 W. Kennedy Boulevard Suite 900 Tampa, FL 33609-1822	local: 1-813-354-9111 toll-free: 1-800-844-0795
Georgia	**Georgia Medical Care Foundation** 1455 Lincoln Parkway, Suite 800 Atlanta, GA 30346	local: 1-404-982-0411 toll-free: 1-800-982-0411

Appendix IV Quality Improvement Organizations (QIOs)

Hawaii	**Mountain-Pacific Quality Health Foundation** 1360 South Beretania Street, Suite 501 Honolulu, HI 96814	local: 1-808-545-2550 toll-free: 1-800-524-6550
Idaho	**Qualis Health** 720 Park Boulevard, Suite 120 Boise, ID 83712	local: 1-208-343-4617 toll-free: 1-800-488-1118
Illinois	**Illinois Foundation for Quality Health Care** 2625 Butterfield Road, Suite 102E Oakbrook, IL 60523-1234	local: 1-630-571-5540 toll-free: 1-800-386-6431
Indiana	**Health Care Excel, Inc.** 2629 Waterfront Parkway East Drive Indianapolis, IN 46214	local: 1-317-347-4500 toll-free: 1-800-288-1499
Iowa	**Iowa Foundation for Medical Care** 6000 Westown Parkway West Des Moines, IA 50266-7771	local: 1-515-223-2900 toll-free: 1-800-383-2856
Kansas	**Kansas Foundation for Medical Care** 2947 S.W. Wanamaker Drive Topeka, KS 66614-4193	local: 1-785-273-2552 toll-free: 1-800-432-0770
Kentucky	**Health Care Excel of Kentucky, Inc.** 1951 Bishop Lane, Suite 400 Louisville, KY 40218	local: 1-502-454-5112 toll-free: 1-800-288-1499
Louisiana	**Louisiana Health Care Review, Inc.** 8591 United Plaza Boulevard, Suite 270 Baton Rouge, LA 70809	local: 1-225-926-6353 toll-free: 1-800-433-4958
Maine	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	local: 1-603-749-1641 toll-free: 1-800-772-0151
Maryland	**Delmarva Foundation for Medical Care** 9240 Centreville Road Easton, MD 21601	local: 1-410-822-0697 toll-free: 1-800-999-3362
Massachusetts	**MassPRO** 245 Winter Street Waltham, MA 02451-1231	local: 1-781-890-0011 toll-free: 1-800-252-5533 *(in-state calls only)*

Appendix IV Quality Improvement Organizations (QIOs)

Michigan	**Michigan Peer Review Organization** 22670 Haggerty Road Suite 100 Farmington Hills, MI 48335-2611	local: 1-248-465-7300 toll-free: 1-800-365-5899
Minnesota	**Stratis Health** 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525	local: 1-952-854-3306 toll-free: 1-877-787-2847
Mississippi	**Mississippi Information and Quality Healthcare** Renaissance Place, Suite 504 385B Highland Colony Parkway Ridgeland, MS 39157-6035	local: 1-601-957-1575 toll-free: 1-800-844-0600
Missouri	**Primaris** 200 North Keene Street Columbia, MO 65201	local: 1-573-817-8300 toll-free: 1-800-735-6776
Montana	**Mountain-Pacific Quality Health Foundation** 3404 Cooney Drive Helena, MT 59602	local: 1-406-443-4020 toll-free: 1-800-497-8232
Nebraska	**CIMRO of Nebraska** 1230 O Street, Suite 120 Lincoln, NE 68508	local: 1-402-476-1399 toll-free: 1-800-458-4262
Nevada	**HealthInsight** 6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118	local: 1-702-385-9933 toll-free: 1-800-748-6773
New Hampshire	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820	local: 1-603-749-1641 toll-free: 1-800-772-0151
New Jersey	**Health Care Quality Strategies** 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816-4026	local: 1-732-238-5570 toll-free: 1-800-624-4557 *(in-state calls only)*
New Mexico	**New Mexico Medical Review Association** 5801 Osuna Road, NE, Suite 200 Albuquerque, NM 87109	local: 1-505-998-9898 toll-free: 1-800-663-6351

Appendix IV Quality Improvement Organizations (QIOs)

New York	**IPRO** 1979 Marcus Avenue Lake Success, NY 11042-1002	local: 1-518-426-3300 toll-free: 1-800-233-0360 (Option #3)
North Carolina	**The Carolina Center for Medical Excellence** 100 Regency Forest Drive, Suite 200 Cary, NC 27518-8598	toll-free: 1-800-722-0468
North Dakota	**North Dakota Health Care Review** 800 31st Avenue, SW Minot, ND 58701	local: 1-701-852-4231 toll-free: 1-888-472-2902
Ohio	**Ohio KePRO** Rock Run Center 5700 Lombardo Center Drive, Suite 100 Seven Hills, OH 44131	local: 1-216-447-9604 toll-free: 1-800-589-7337
Oklahoma	**Oklahoma Foundation for Medical Quality** 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134-2600	local: 1-405-840-2891 toll-free: 1-800-522-3414
Oregon	**Acumentra Health** 2020 SW Fourth Avenue, Suite 520 Portland, OR 97201	local: 1-503-279-0100 toll-free: 1-800-344-4354
Pennsylvania	**Quality Insights of Pennsylvania** 2601 Market Place Street, Suite 320 Harrisburg, PA 17110	local: 1-717-671-5425 toll-free: 1-877-346-6180
Puerto Rico	**QIPRO, Inc.** 2 Ponce de Leon Avenue San Juan, PR 00918	local: 1-787-641-1240 toll-free: 1-800-981-5062 *(PR calls only)*
Rhode Island	**Rhode Island Quality Partners, Inc.** 235 Promenade Street, Suite 500 P.O. Box 18 Providence, RI 02908	local: 1-401-528-3200 toll-free: 1-800-662-5028
South Carolina	**Carolina Center for Medical Excellence** 246 Stoneridge Drive, Suite 200 Columbia, SC 29210	local: 1-803-251-2215 toll-free: 1-800-922-3089

Appendix IV Quality Improvement Organizations (QIOs)

South Dakota	**South Dakota Foundation for Medical Care** 2600 West 49th Sreet, Suite 300 P.O. Box 7406 Sioux Falls, SD 57117-7406	local: 1-605-336-3505 toll-free: 1-800-658-2285
Tennessee	**QSource** 3175 Lenox Park Boulevard, Suite 309 Memphis, TN 38115	local: 1-901-528-2655 toll-free: 1-800-528-2655
Texas	**TMF Health Quality Institute** 5918 West Courtyard Drive Bridge Point, Suite 300 Austin, TX 78730-5036	local: 1-512-329-6610 toll-free: 1-800-725-9216
Utah	**HealthInsight** 348 E 4500 South, Suite 300 Salt Lake City, UT 84107	local: 1-801-892-0155 toll-free: 1-800-748-6773
Vermont	**Northeast Health Care Quality Foundation** 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	local: 1-603-749-1641 toll-free: 1-800-772-0151
Virginia	**Virginia Health Quality Center** 4510 Cox Road, Suite 400 Glen Allen, VA 23060	local: 1-804-289-5320 toll-free: 1-800-854-5244
Washington	**QualisHealth** 10700 Meridian Avenue North, Suite 100 Seattle, WA 98133	local: 1-206-364-9700 toll-free: 1-800-949-7536
West Virginia	**West Virginia Medical Institute** 3001 Chesterfield Place Charleston, WV 25304	local: 1-304-346-9864 toll-free: 1-800-642-8686
Wisconsin	**MetaStar** 2909 Landmark Place Madison, WI 53713	local: 1-608-274-1940 toll-free: 1-800-362-2320
Wyoming	**Mountain-Pacific Quality Health Foundation** 2206 Dell Range Boulevard, Suite G Cheyenne, WY 82009	local: 1-307-637-8162 toll-free: 1-877-810-6248

9. 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 state you live in.

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 prescription drug plans, like our Plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

10. How Much You Pay for Your Part D Prescription Drugs — Your Plan Benefits

Your monthly premium for our Plan

Contact your Commonwealth of Virginia Retiree Health Benefits Program Benefits Administrator for information about your plan premium.

If you are getting extra help with paying for your drug coverage, your premium reduction amount is listed in your **"Evidence of Coverage Rider for Those Who Receive Extra Help Paying for Their Prescription Drugs."** You can also get that information by calling Customer Service. If you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your monthly plan premiums. Please contact your SPAP to determine what benefits are available to you. Note that there is not an SPAP in every state, and in some states the SPAP has another name. See Section 8.

You can find additional information about your premium and how to pay your plan premium in Section 1.

How much you pay for Part D prescription drugs

This section has a chart that tells you what you must pay for covered drugs. These are the benefits you get as a member of our Plan. For more detailed information about your benefits, you may request a Summary of Benefits from Customer Service. You can also view it on our website.

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

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, 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. Refer to your plan formulary to see what drugs we cover and what tier they are on. (More information on the formulary is included later in this section.)

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 the **"Evidence of Coverage Rider for Those Who Receive Extra Help Paying for Their Prescription Drugs."** If you do not already qualify for extra help, see "Do you qualify for extra help?" in Section 1 for more information.

Deductible (does not apply to generics)

You will pay a yearly deductible of $295.

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 the coinsurance or co-payment. Your coinsurance or co-payment will vary depending on the drug and where the prescription is filled. Once your true out-of-pocket expenses reach $4,350 you will reach your catastrophic coverage level.

After you satisfy the deductible, you will have to pay the following for your prescription drugs*:

Drug Tier	Network retail/ long-term care cost-sharing (up to a 34-day supply)	Network retail cost-sharing (up to a 60-day supply)	Network retail cost-sharing (up to a 90-day supply)	Network mail-order cost-sharing (up to a 90-day supply)
Generics (Tier 1)	$7.00 co-payment	$14.00 co-payment	$21.00 co-payment	$7.00 co-payment
Preferred brand name (Tier 2)	$25.00 co-payment	$50.00 co-payment	$75.00 co-payment	$50.00 co-payment
Non-preferred brand name (Tier 3)	75% coinsurance	75% coinsurance	75% coinsurance	75% coinsurance
Specialty (Tier 5)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance

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 $4,350 out of pocket for the year. When the total amount you have paid toward your deductible, coinsurance and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,350, you will qualify for catastrophic coverage. During catastrophic coverage, you will pay: the greater of 5% coinsurance, or $2.40 for generics or drugs that are treated like generics and $6.00 for all other drugs. We will pay the rest.

Vaccine coverage (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 someone 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, following our out-of-network paper claims policy (see Section 2), and then you will be reimbursed up to our normal coinsurance or co-payment for that vaccine. In some cases, you will be responsible for the difference between what we pay and what the out-of-network provider charges you. 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, you are responsible for all of the costs associated with vaccines (including their administration) during the deductible phase of your benefit.

Vaccine Coverage (including administration)

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed):
The pharmacy	The pharmacy (not possible in all states)	You pay your normal coinsurance or co-payment for the vaccine.
Your doctor	Your doctor	You pay up front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal coinsurance or co-payment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay.*
The pharmacy	Your doctor	You pay your coinsurance or co-payment for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine less 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.

If you receive a vaccine and pay out of pocket for either the vaccine or its administration, you may submit a claim form for reimbursement. Your claim will need to meet the requirements listed on the claim form for reimbursement. To obtain a copy of a vaccine direct claim form, either visit our website or contact Customer Service.

We can help you understand the costs associated with vaccines (including administration) available under our Plan 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 as 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 and co-payments.

When you have spent a total of $4,350 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 **do 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
- Non-Part D drugs

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 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). (SPAPs have different names in different states. See Section 8 for the name and phone numbers for the SPAP in your area.);
- 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:

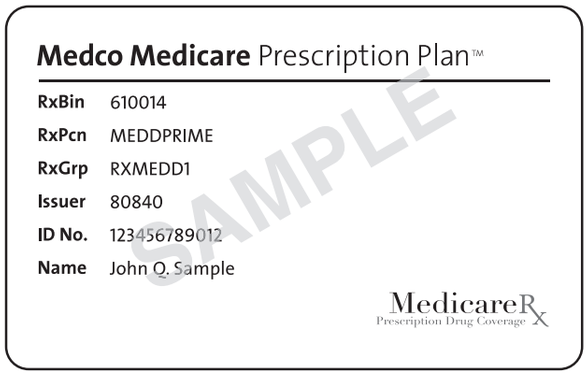
- Payments for drug costs made by your employer/former employer or union on your behalf;
- Group health plans;
- Insurance plans and government-funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third-party arrangements with a legal obligation 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 let us know.

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 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, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Sample plan membership card

Here is an example of what your plan membership card looks like. See Section 1 for more information on using your plan membership card.



Excluded Drugs

This part of Section 10 talks about drugs that are "excluded," meaning they aren't normally covered by a Medicare 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 EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid for or covered (appeals are discussed in Section 5).

- A Medicare prescription drug plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare prescription drug plan can't cover a drug purchased outside the United States and its territories.
- 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 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. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI, or its successor.) 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.

In addition, 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	

Medco Health Solutions, Inc., 100 Parsons Pond Drive, Franklin Lakes, NJ 07417

Medco is a registered trademark of Medco Health Solutions, Inc.
Medco Medicare Prescription Plan is a registered trademark of Medco Health Solutions, Inc.
© 2008 Medco Health Solutions, Inc. All rights reserved.

E00CVA9A

medco®