



AmeriHealth[®]Rx

A Medicare-Approved Prescription Drug Plan

2009



Effective

January 1, 2009

through

December 31, 2009

Evidence of Coverage

AmeriHealth[®] Rx

New Jersey
S4496

This Is Your 2009 Evidence of Coverage (EOC)

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Section 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 explains your rights, benefits, and responsibilities as a member of our plan and is in effect from January 1, 2009 - December 31, 2009. There is more than one plan described in this EOC. Please refer to the cover sheet you received with this information to identify which plan you are enrolled in. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage 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 enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

THE GEOGRAPHIC SERVICE AREA FOR OUR PLAN

The state in our service area is listed below.

New Jersey

HOW DO I KEEP MY MEMBERSHIP RECORD UP TO DATE?

We have a membership record about you. Your membership record has information from your enrollment form, 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 Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your 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 Member Services 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 Member Services. 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. An Explanation of Benefits is also available upon request. To get a copy, please contact Member Services.

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** – The amount paid before you start getting prescription coverage.
 - **Amount paid for prescriptions** – The amounts paid that count towards your initial coverage limit.
 - **Total out-of-pocket costs that count toward catastrophic coverage** – The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your deductible, coinsurance or copayments, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

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 all or part of the monthly premium.)

Your monthly premium for our plan is listed in Section 10.

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

Note: If you are getting extra help (LIS) with paying for your drug coverage, the premium amount that you pay as a member of this plan is listed in your “Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs.” Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP at the phone number listed in Section 8 to determine what benefits are available to you.

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium. To enroll in one these options, or to change your existing payment option, please contact Member Services.

Option One: Pay your monthly plan premium directly to our plan.

You may decide to pay your monthly plan premium directly to our plan.

Direct Pay – Your monthly premium bill is sent to your home, you write the check and send it directly to us.

If you are enrolled in a plan that charges a monthly premium you should be aware of the following:

- Your premium due date is noted on your bill.
- Your bank may apply a penalty to your account if your check bounces because of insufficient funds. AmeriHealth Rx NJ does not charge for insufficient funds.
- Checks should be mailed to:
AmeriHealth Rx NJ
P.O. Box 1788
Newark, NJ 07101-1788
- Payments can be also made in person at:
1901 Market Street
1st Floor
Philadelphia, PA 19103
8:30 a.m. to 4:30 p.m., Monday through Friday.

Please do not write any notes or correspondence to us on your premium bill.

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank account:

ZipCheck® – A fully automatic, computerized way to have your monthly premium payment deducted directly from your bank account.

ZipCheck deductions occur on the 5th of each month, unless the 5th falls on a weekend or bank holiday. At that time the deduction occurs on the next business day.

If you are interested in the ZipCheck option, call the Member Services telephone number listed in [Section 8](#).

Option two: You may have your monthly plan premium directly deducted from your monthly Social Security payment.

Contact Member Services for more information on how to pay your monthly plan premium this way.

Note: We don't recommend this option if you are getting extra help for your monthly plan premium payment from another payer, like a State Pharmaceutical Assistance Program (SPAP). (SPAPs have different names in different states. See [Section 8](#) for the name and phone number for the SPAP in your area.) Social Security can only withhold the full amount of the monthly plan premium and will not recognize any monthly plan premium payments made by other payers as part of this process.

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. If our monthly plan premium changes for next year we will tell you in October and the change 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.

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

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 not creditable (as good as Medicare's drug coverage);
- any period of time that you didn't have creditable prescription drug coverage 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 your monthly plan premiums are late, we will tell you in writing that if you don't pay your monthly plan premium by a certain date, which includes a grace period, we will end your membership in our plan. Our plan's grace period is 180 days from the premium due date.

Should you decide later to re-enroll in our plan, or to enroll in another plan that we offer, you will have to pay any late monthly plan premiums that you didn't pay from your previous enrollment in our plan.

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 copayments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help 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 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 copayment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount when you get your prescription at a pharmacy, our plan has established a process that will allow you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us. To learn more about this process, call the Member Services number in [Section 8](#).

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

IMPORTANT INFORMATION

We will send you a **Coordination of Benefits Survey** 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 Member Services to update your membership records.

Section 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 or copayments. 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 number 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 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 Member Services to find out if your drug is on the formulary or to request an updated copy of our formulary.

What are drug tiers?

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

If we remove drugs from the formulary, or add prior authorizations and/or quantity limits on a drug or move a drug to a higher cost-sharing tier and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year. However, if a brand-name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60-day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to 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 Member Services to be sure it isn't covered. If Member Services 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 Member Services 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 Member Services if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to 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 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 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term care facility (like a nursing home), we will cover a temporary 31-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 dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

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

Please note that our transition policy applies only to those drugs that are "Part D drugs" and 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 4 tablets per 30 days for Actonel 35mg.

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 Member Services. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See [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 **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

If you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in 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

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

Each year (prior to November 15), your 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. 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.

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 Member Services.

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 Member Services 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 FutureScripts® Secure at **1-888-678-7015**, 24 hours a day 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 copayment) 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 services to fill prescriptions for some drugs. These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

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

Generally, it takes the mail-order pharmacy 10 to 14 days to process your order and ship it to you. However, sometimes your mail-order may be delayed. If your mail-order has been delayed past the 14 days, please contact Caremark's® Member Services at **1-866-236-6714**, Monday through Friday from 6 a.m. to 11 p.m., or Saturday and Sunday from 7 a.m. to 11 p.m. If you need to obtain approval for a supply of your medication at a retail pharmacy in the AmeriHealth Rx network, please contact FutureScripts® Secure at **1-888-678-7015**, 24 hours a day. You may need to obtain a written prescription from your doctor.

You are not required to use mail-order prescription drug services to obtain an extended supply of mail-order medications. Instead, you have the option of using another network retail pharmacy in our network to obtain a supply of mail-order medications. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for an extended supply of mail-order 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 amounts for an extended supply of mail-order medications. Your Pharmacy Directory contains information about retail pharmacies in our network at which you can obtain an extended supply of mail-order medications. You can also call Member Services for more information.

To get order forms and information about filling your prescriptions by mail, please contact FutureScripts® Secure at **1-888-678-7015**. Please note that you must use our network mail-order services. Prescription drugs that you get through any other mail-order services are not covered.

How do you fill prescriptions outside the network?

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited, 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 Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just copayment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. 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 order to receive benefits through our plan, prescriptions must be filled at a network pharmacy. However, covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside the plan's service area where there is no network pharmacy. You will need to pay the entire cost of the drug and then our plan will reimburse you the full amount minus the applicable copayments. If you do fill your prescriptions at an out-of-network pharmacy, you will only be allowed to obtain a 31-day supply of drugs.

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 copayment) 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 copayment) 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](#).
- **If you are retroactively enrolled in our plan because you were Medicaid eligible.** As discussed in the section below (“Reimbursing plan members for coverage during retroactive periods”), you must submit a paper claim in order to be reimbursed for out-of-pocket expenses you had during this time period (and that were not reimbursed by other insurance). 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 coverage gap or deductible period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the plan’s benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.
- **Copayments for drugs provided under a drug manufacturer patient assistance program.** If you get help from, and pay copayments 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 towards qualifying you for catastrophic coverage.

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 Member Services. **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](#).

Reimbursing plan members for coverage during retroactive periods

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

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 Medicare-covered skilled nursing facility stay, we will cover your prescription drugs as long as the drug meets 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 Part B). When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this plan and join a Medicare Advantage plan, 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 Member Services.

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

Only Native Americans and Alaska Natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies through our plan's pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies). Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, contact Member Services.

Home infusion pharmacies

Our plan will cover home infusion therapy if:

- Your prescription drug is on our plan's formulary or a formulary exception has been granted for your prescription drug.
- Your prescription is written by an authorized prescriber.
- You get your home infusion services from our plan's network pharmacy.

Note: Your Part D benefit will cover only the cost of the prescription drugs and not the cost of other services and supplies associated with your home infusion therapy, such as nursing services and supplies. Please refer to your medical benefits for coverage of these services.

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

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.

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

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. Section 8 of this booklet tells how to contact your SHIP, which stands for State Health Insurance Assistance Program. 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

Department of Health and Senior Services
P. O. Box 360
Trenton, NJ 08625-0360
609-292-7837
Toll-free in NJ: 1-800-367-6543.

YOUR RIGHT TO GET INFORMATION ABOUT OUR PLAN

You have the right to get information from us about our plan. This includes information about our financial condition, and how our plan compares to other health plans. To get any of this information, call Member Services.

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 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 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 Member Services.

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 prior authorization, which may apply to your plan. Please review our formulary website or call Member Services 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 or care. 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 Member Services.

HOW TO GET MORE INFORMATION ABOUT YOUR RIGHTS

If you have questions or concerns about your rights and protections, you can

1. Call Member Services at the number 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 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 Member Services 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 Member Services 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.
- **You are required to tell our plan if you have additional drug coverage. Call Member Services.**
- 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 copayment for your covered services. You must pay for services that aren’t covered.
- Notifying us 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, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

Section 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 Member Services.
- 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 time frame.
- 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 Member Services.

FILING A GRIEVANCE WITH OUR PLAN

If you have a complaint, you or your representative may call the phone number 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 the Grievance Complaint process.** To use the formal grievance procedure, submit your grievance in writing to: Medicare Member Appeals Unit, P.O. Box 13652, Philadelphia, PA 19101-3652.

Expedited (Fast) Grievance Process

As a member you can file an expedited grievance with AmeriHealth Rx NJ for the following reasons:

- AmeriHealth Rx PA/WV makes a decision to invoke an extension to the coverage determination or reconsideration time frames.
- AmeriHealth Rx PA/WV refuses to grant a member's request for an expedited coverage determination or reconsideration.

AmeriHealth Rx NJ must respond within 24 hours of receiving your expedited grievance request. To file an expedited grievance, please call: **1-888-678-7007** (TTY/TDD: **1-888-457-3002**) 7 days a week, 8 a.m to 8 p.m. or mail a written request to Medicare Member Appeals Unit, P.O. Box 13652, Philadelphia, PA 19101-3652.

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 time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. 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 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 number of the QIO in your state.

Section 5 – Complaints and Appeals About Your Part D Prescription Drug(s)

INTRODUCTION

This section explains how you ask for coverage of your Part D drug(s) 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 OR PAYMENT

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 or quantity limits. 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 “Filling Prescriptions Outside of 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 unless coverage is through an enhanced plan that covers those excluded drugs.
- 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 non-preferred tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the copayment 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 the specialty tier.

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the plan formulary 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 copayment or coinsurance amount we require you to pay for the drug.

You may call us at the phone number 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 Member Services.

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 time frame, 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 believe 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 benefit 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 may 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 or quantity limits, we must give you our decision no later than 72 hours after we receive your physician’s “supporting statement” explaining why the drug you are asking for is medically necessary.

If you have not received an answer from us within 72 hours after we receive your request (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 ask 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 number 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 may 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 number 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 seven 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 seven 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 it reviews your case, a decision will be made according to the rules established by the federal judiciary.

If the judge decides in your favor:

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.

Section 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

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. 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 who move, 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.

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.

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 Member Services. You may also call **1-800-MEDICARE (1-800-633-4227)** to request disenrollment from our plan. TTY users should call **1-877-486-2048**.
- **If you would like to end your membership without joining any other Medicare health or Prescription Drug Plan:** Contact Member Services 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 users should call **1-877-486-2048**. Your enrollment in Original Medicare will be effective January 1.

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 drug coverage), you may have to pay a penalty if you join later.

ENROLLMENT PERIOD	WHEN?	EFFECTIVE DATE
<p>Fall open enrollment (annual election period) Time to review health and drug coverage and make changes.</p>	<p>Every year from November 15 to December 31</p>	<p>January 1</p>
<p>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.</p> <p>Examples:</p> <p>If you are in a 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.</p> <p>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.</p> <p>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.</p>	<p>Every year from January 1 to March 31</p>	<p>First day of next month after plan receives your enrollment request</p>
<p>Special Enrollment Periods for limited special exceptions, such as:</p> <ul style="list-style-type: none"> • you have a change in residence; • you have Medicaid; • you are eligible for extra help with Medicare prescriptions; • you live in an institution (such as a nursing home). 	<p>Determined by exception</p>	<p>Generally, first day of next month after plan receives your enrollment request</p>

For more information about the options available to you during these enrollment periods, contact Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY 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 YOUR MEMBERSHIP ENDS, YOU MUST KEEP GETTING YOUR MEDICARE PRESCRIPTION DRUG COVERAGE THROUGH OUR PLAN.

If you leave our plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). 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 services, 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 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 plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our plan’s service area.
- 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 behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our plan. We cannot make you leave our plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the inspector general for additional investigation.

- If you do not pay the plan premiums, we will tell you in writing that you have a 180-day grace period during which you may pay the plan premiums before your membership ends.

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.

Section 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 drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage – The phase in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$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 the plan may impose before services are covered; (2) any fixed “copayment” amounts that a plan may require be paid when specific services are received; or (3) any “coinsurance” amount that must be paid as a percentage of the total amount paid for drugs.

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

Deductible – The amount you must pay for the drugs you receive before our plan begins to pay its share of your covered 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 form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of 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 Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period after you have met your deductible and before your total drug expenses, have reached \$2,700, including amounts you've paid and what our plan has paid on your behalf.

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. A 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 plan 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 (MAPD)**. 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 Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare supplement insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in 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).

Member Services – 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 Member Services.

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.

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.

Preferred Provider Organization Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing may be higher when plan benefits are received from out-of-network providers.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. In a prescription drug plan, 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 5 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.

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

Section 8—Helpful Phone Numbers and Resources

Contact Information for our plan Member Services

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

CALL 1-888-678-7007 Calls to this number are free.
Hours of Operation: 7 days a week, 8 a.m. to 8 p.m.

TTY/TDD 1-888-457-3002 This number requires special telephone equipment.
Calls to this number are free.

FAX 1-888-289-3029

WRITE P.O. Box 41535, Philadelphia, PA 19101-1535

WEBSITE www.amerihealth65.com

Contact Information for Grievances, Coverage Determinations, and Appeals

Part D Grievances, Appeals, and Coverage Determinations (about your Part D Prescription Drugs)

CALL 1-888-678-7007. Calls to this number are free.
Hours of Operation: 7 days a week, 8 a.m. to 8 p.m.

TTY/TDD 1-888-457-3002. This number requires special telephone equipment.
Calls to this number are free.

FAX 1-888-289-3008

WRITE Medicare Member Appeals Unit
P.O. Box 13652
Philadelphia, PA 19101-3652

For information about Part D coverage determinations, grievances, and appeals, see Section 4 and 5.

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

CALL 1-888-678-7015, Option #1. Calls to this number are free.
Hours of operation: 7 days a week, 8 a.m. to 8 p.m.

WRITE Medicare Part D Paper Claims, FSS
P.O. Box 37694
Philadelphia, PA 19101-0694

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 Resources,” or call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

Division of Aging and Community Services - State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SHIP has information about Medicare Advantage plans, Medicare Prescription Drug 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 contact your local SHIP at:

Division of Aging and Community Services
New Jersey Department of Health & Senior Services
P.O. Box 807
Trenton, NJ 08562-0807
or call 1-800-367-6543.

You may also find the website for SHIP at **www.medicare.gov** under “Search Tools” by selecting “Helpful Phone Numbers and Websites.”

Healthcare Quality Strategies - Quality Improvement Organization (QIO)

“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 contact Healthcare Quality Strategies, Inc. at:

557 Cranbury Road, Suite 21
East Brunswick, NJ 08816-4026
or call 1-732-238-5570.

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 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 “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:

New Jersey Department of Human Services
P.O. Box 712
Trenton, NJ 08608
or call 1-800-356-1561.

Social Security

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

Pharmaceutical Assistance to the Aged and Disabled Program (PAAD) - 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 at:

Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)
P.O. Box 360
Trenton, NJ 08625-0360
or call at 1-609-292-7837 or 1-800-367-6543.

The website for PAAD is **www.state.nj.us/health/seniorbenefits/pbp/**.

Railroad Retirement Board

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

Employer (or “group”) coverage

If you 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/union benefits administrator or Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (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/union benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

Section 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.

REPORT FRAUD, WASTE AND ABUSE

Health care fraud is a violation of state and/or federal law. The AmeriHealth Corporate and Financial Investigations Department helps to protect members and providers from fraudulent and abusive practices. If you know of or suspect health insurance fraud, please report it. You are not required to provide identifying information about yourself when reporting fraud. Call the toll free Fraud Hotline at **1-866-282-2707**.

Section 10 – How Much You Pay for Your Part D Prescription Drugs

YOUR MONTHLY PREMIUM FOR OUR PLAN

The table below shows the monthly plan premium amount for each plan.

PLAN NAME	MONTHLY PREMIUM
Option 1	\$32.20
Option 2	\$40.20

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

If you are getting extra help with paying for your drug coverage, the Part D premium amount that you pay as a member of this plan is listed in your “Evidence of Coverage Rider for Those Who Receive Extra Help for Their Prescription Drugs.” You can also get that information by calling Member Services. 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 more information about paying 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, please refer to our Summary of Benefits. If you do not have a current copy of the [Summary of Benefits](#), you can view it on our website or contact Member Services to request one.

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, the period after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described in this document. 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.

AMERIHEALTH RX NJ OPTION 1

Deductible

You will pay a yearly deductible of \$295. After you meet the deductible, you will reach the initial coverage period.

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 copayment/coinsurance. Your copayment/coinsurance will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs:

Drug Tier	Network Retail Cost-Sharing (30-day supply)	Network Retail Cost-Sharing (90-day supply)	Network Long-Term-Care Cost-Sharing (31-day supply)	Network Mail-Order Cost-Sharing (90-day supply)	Out-of-Network Cost-Sharing (30-day supply)
Generic	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Preferred Brand	\$30 copayment	\$90 copayment	\$30 copayment	\$90 copayment	\$30 copayment
Non-Preferred Brand	\$88 copayment	\$264 copayment	\$88 copayment	\$264 copayment	\$88 copayment
Specialty Tier	25%	25%	25%	25%	25%

Once your total drug costs reach \$2,700, you will reach your initial coverage limit. Your initial coverage limit is calculated by adding payments made by this plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this plan, the amount they spend may count towards your initial coverage limit.

Coverage gap

After your total drug costs reach \$2,700, you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach \$4,350 and you qualify for catastrophic coverage.

Once your total drug costs reach \$4,350, you will qualify for catastrophic coverage.

Catastrophic coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4,350 out of pocket for the year. When the total amount you have paid toward your deductible, copayments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches \$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.

AMERIHEALTH RX NJ OPTION 2

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 copayment/coinsurance. Your copayment/coinsurance will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs:

Drug Tier	Network Retail Cost-Sharing (30-day supply)	Network Retail Cost-Sharing (90-day supply)	Network Long-Term-Care Cost-Sharing (31-day supply)	Network Mail-Order Cost-Sharing (90-day supply)	Out-of-Network Cost-Sharing (30-day supply)
Generic	\$7 copayment	\$21 copayment	\$7 copayment	\$14 copayment	\$7 copayment
Preferred Brand	\$37 copayment	\$111 copayment	\$37 copayment	\$74 copayment	\$37 copayment
Non-Preferred Brand	\$70 copayment	\$210 copayment	\$70 copayment	\$140 copayment	\$70 copayment
Specialty Tier	33%	33%	33%	33%	33%

Once your total drug costs reach \$2,700, you will reach your initial coverage limit. Your initial coverage limit is calculated by adding payments made by this plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this plan, the amount they spend may count towards your initial coverage limit.

Coverage gap

After your total drug costs reach \$2,700, you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach \$4,350 and you qualify for catastrophic coverage.

Once your total drug costs reach \$4,350, you will qualify for catastrophic coverage.

Catastrophic coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4,350 out of pocket for the year. When the total amount you have paid toward your deductible, copayments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches \$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/copayment 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 or coverage gap phase(s) of your benefit.

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/copayment 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/copayment for the vaccine (including administration).
The pharmacy	Your doctor	You pay your normal coinsurance/copayment 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.

Note: We will reimburse you our normal coinsurance/copayment minus the physician's charge and copay.

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 Member Services.

HOW IS YOUR OUT-OF-POCKET COST CALCULATED?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage 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” or “copayments” up to the initial coverage limit;
- any payments you make for drugs in the coverage gap;
- payments you made this year under another Medicare Prescription Drug Plan prior to your enrollment in our plan.

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, including prescription drugs covered by Part A or Part B, and other drugs excluded from coverage by Medicare.

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 number 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:

- 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.

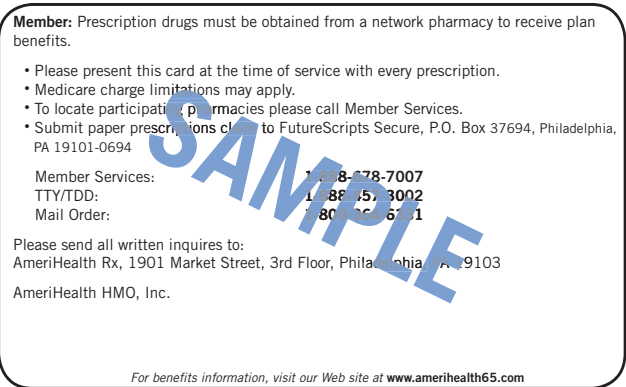
We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the plan's benefit, you may submit documentation and have it count towards 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.



The image shows a sample membership card for AmeriHealth Rx. The card features the AmeriHealth Rx logo at the top left, which includes a stylized American flag. Below the logo, it says "A Medicare-Approved Prescription Drug Plan". The cardholder's name and ID are listed as "SAMPLE, JOHN Q" and "Q4D12345678 00". The issuer information is "ISSUER: 80840" and "HMO - S4496-[XXX]". The card also displays the Medicare Rx logo and the text "Medicare Rx Prescription Drug Coverage". At the bottom, it provides the FutureScripts Secure RXBIN:012353 and RXPCN:03820000. A large "SAMPLE" watermark is overlaid diagonally across the card.



This section contains member instructions and contact information. It starts with a "Member:" note stating that prescription drugs must be obtained from a network pharmacy. A bulleted list of instructions includes: presenting the card with every prescription, noting Medicare charge limitations, locating participating pharmacies, and submitting paper prescriptions to FutureScripts Secure. Contact information for Member Services is provided: 1-800-678-7007, TTY/TDD: 1-800-457-3002, and Mail Order: 1-800-366-6771. The address for inquiries is AmeriHealth Rx, 1901 Market Street, 3rd Floor, Philadelphia, PA 19103. The website www.amerhealth65.com is listed for benefits information. A large "SAMPLE" watermark is overlaid diagonally across the text.

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, 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	

If you receive extra help, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.



A Medicare-Approved Prescription Drug Plan

P.O. Box 41535
Philadelphia, PA 19103-1535
www.amerihealth65.com



If you are a **member** and have questions,
please call toll free, **1-888-678-7007**
(TTY/TDD: **1-888-457-3002**)
Seven days a week 8 a.m. to 8 p.m.

If you are **not yet a member** and have questions,
please call toll free, **1-800-898-3492**
(TTY/TDD: **1-877-219-5457**)
Seven days a week 8 a.m. to 8 p.m.

AmeriHealth HMO, Inc.

