AmeriHealth Advantage
Evidence of Coverage and Disclosure Information
Alabama, Delaware, District of Columbia, Florida, Georgia, Indiana, Kentucky, Louisiana, Maryland, Ohio and Tennessee

Effective January 1, 2006 through December 31, 2006

1-888-457-3007
TTY/TDD: 1-888-457-3002

Underwritten by QCC Insurance Company
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Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of AmeriHealth Advantage

January 1–December 31, 2006

This Evidence of Coverage gives the details about your Medicare Prescription Drug Coverage. This Evidence of Coverage is an important legal document. Please keep it in a safe place.

AMERIHEALTH ADVANTAGE MEMBER SERVICES DEPARTMENT:

For help or information, please call the Member Services Department, Monday through Friday, 8:00 A.M. to 6:00 P.M. Calls to these numbers are free:

- Phone: 1-888-457-3007
- TTY/TDD: 1-888-457-3002
- Website: www.amerihealthpdp.com
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WELCOME TO AMERIHEALTH ADVANTAGE!

We are pleased that you’ve chosen our Plan.

AmeriHealth Advantage is a Medicare Prescription Drug Plan.

Now that you are enrolled in AmeriHealth Advantage, a Medicare Prescription Drug Plan, you are getting your Medicare Prescription Drug Coverage through QCC Insurance Company.

Throughout the remainder of this Evidence of Coverage we refer to AmeriHealth Advantage as “Plan.”

This Evidence of Coverage explains how to get your Medicare prescription drug coverage through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. It also explains our responsibilities to you. The information in this Evidence of Coverage is in effect for the time period from January 1, 2006 through December 31, 2006.
This Evidence of Coverage gives you the details, including:

• What is covered in our Plan and what is not 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, including your choices for continuing Medicare Prescription Drug Coverage.

• If you need this Evidence of Coverage in a different format (such as in Braille or audiotapes), please call us so we can send you a copy.

Please tell us how we’re doing.

We want to hear from you about how well we are doing as your Medicare Prescription Drug Plan. You can call or write to us at any time — your comments are always welcome, whether they are positive or negative. From time to time, we conduct surveys that ask our members to tell about their experiences with this Plan. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

HOW TO CONTACT OUR PLAN’S MEMBER SERVICES DEPARTMENT.

If you have any questions or concerns, please call or write to the Member Services Department. We will be happy to help you. Our business hours are Monday through Friday from 8:00 A.M. to 6:00 P.M.

CALL: 1-888-457-3007. This number is also on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

TTY/TDD: 1-888-457-3002. This number requires special telephone equipment. It is on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

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

VISIT: 1901 Market Street, 1st Floor, Philadelphia, PA 19103

HOW TO CONTACT THE MEDICARE PROGRAM AND THE 1-800-MEDICARE (TTY/TDD 1-877-486-2048) HELPLINE

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. “CMS” stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Prescription Drug Plans (including our Plan).
Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free.

- Use a computer to look at [www.medicare.gov](http://www.medicare.gov), the official government website for Medicare information. This website gives you a lot of up-to-date information about Medicare and nursing homes. It includes Medicare publications you can print directly from your computer. It has tools to help you compare Medicare Health Plans and Prescription Drug Plans in your area. You can also search the “Helpful Contacts” section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

**SHIP—AN ORGANIZATION IN YOUR STATE THAT PROVIDES FREE MEDICARE HELP AND INFORMATION**

“SHIP” stands for State Health Insurance Assistance Program. SHIPs are organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare health plans and about Medigap (Medicare supplement insurance) policies.

You can find contact information for the SHIP in your state below. You can also find the website for your local SHIP at [www.medicare.gov](http://www.medicare.gov).

**ALABAMA**

Alabama Department of Senior Services  
770 Washington Avenue  
RSA Plaza Suite 470  
Montgomery, AL 36130  
Phone: 1-334-242-5743

**DELAWARE**

ELDERinfo  
Delaware Insurance Department  
841 Silver Lake Boulevard  
Dover, DE 19904  
Phone: 1-800-282-8611

**DISTRICT OF COLUMBIA**

George Washington University National Law Center  
HICP  
2136 Pennsylvania Avenue, NW  
Washington, DC 20092  
Phone: 1-202-739-0668
FLORIDA
Serving Health Insurance Needs of Elders (SHINE)
Florida Department of Elder Affairs
4040 Esplanade Way
Suite 2805
Tallahassee, FL 32399-7000
Phone: 1-800-963-5337

GEORGIA
Division of Aging Services
Two Peachtree Street, NW
Suite 9385
Atlanta, GA 30303-3142
Phone: 1-404-657-5258

INDIANA
Senior Health Insurance Information Program
Indiana Department of Insurance
311 W. Washington Street, Suite 300
Indianapolis, IN 46204-2787
Phone: 1-317-233-3475

KENTUCKY
Cabinet for Health and Family Services
Office of the Secretary
275 East Main Street
Frankfort, KY 40621
Phone: 1-800-372-2973

LOUISIANA
Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70802
Phone: 1-800-259-5301

MARYLAND
Maryland Department of Aging
301 West Preston Street
Suite 1007
Baltimore, MD 21201
Phone: 1-410-767-1100
QUALITY IMPROVEMENT ORGANIZATION – A GROUP OF DOCTORS AND HEALTH PROFESSIONALS IN YOUR STATE WHO REVIEW MEDICAL CARE AND HANDLE CERTAIN TYPES OF COMPLAINTS FROM PATIENTS WITH MEDICARE

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts 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. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in the QIO review written quality of care complaints made by Medicare patients. See Section 6 for more information about complaints. You can find contact information for the QIO in your state below.

ALABAMA

Alabama Quality Assurance Foundation
Two Perimeter South
Suite 200 W
Birmingham, AL 32543
Phone: 1-205-970-1600

DELAWARE

Quality Insights of Delaware
Baynard Building
Suite 100
3411 Silverside Road
Wilmington, DE 19810-4812
Phone: 1-302-478-3600
DISTRICT OF COLUMBIA

Delmarva Foundation for Medical Care
1620 L Street, NW
Suite 1275
Washington, DC 20036
Phone: 1-202-293-9650

FLORIDA

Florida Medical Quality Assurance
5201 W. Kennedy Boulevard
Suite 900
Tampa, FL 33609-1812
Phone: 1-813-354-9111

GEORGIA

Georgia Medical Care Foundation
1455 Lincoln Parkway
Suite 800
Atlanta, GA 30346
Phone: 1-404-982-0411

INDIANA

Health Care Excel
2629 Waterfront Parkway East Drive
Indianapolis, IN 46214
Phone: 1-317-347-4500

KENTUCKY

Health Care Excel
1951 Bishop Lane, Suite 300
Louisville, KY 40218
Phone: 1-502-454-5112

LOUISIANA

Louisiana Health Care Review
8591 United Plaza Boulevard, Suite 270
Baton Rouge, LA 70809
Phone: 1-225-926-6353

MARYLAND

Delmarva Foundation for Medical Care
9240 Centreville Road
Easton, MD 21601
Phone: 1-410-822-0697
OHIO

Ohio KePro
Rock Run Center, Suite 100
5700 Lombardo Center Drive
Seven Hills, OH 44131
Phone: 1-216-447-9604

TENNESSEE

Center for Healthcare Quality
3175 Lenox Park Boulevard
Suite 309
Memphis, TN 38115
Phone: 1-800-528-2655

OTHER ORGANIZATIONS

Medicaid agency—a state government agency that handles health care programs for people with low incomes.

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also 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:

ALABAMA

Medicaid Agency of Alabama
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624
Phone: 1-800-362-1504

DELAWARE

Delaware Health and Social Services
1901 N. DuPont Highway
P.O. Box 906, Lewis Bldg.
New Castle, DE 19720
Phone: 1-800-372-2022

DISTRICT OF COLUMBIA

DC Health Family
825 North Capitol Street, NE
5th Floor
Washington, DC 20002
Phone: 1-202-442-5999
FLORIDA

Agency for Health Care Administration of Florida
P.O. Box 13000
Tallahassee, FL 32317-3000
Phone: 1-888-419-3456

GEORGIA

Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
Phone: 1-866-322-4260

INDIANA

Family and Social Services Administration of Indiana
402 W. Washington Street
P.O. Box 7083
Indianapolis, IN 46207-7083
Phone: 1-800-889-9949

KENTUCKY

Cabinet for Health Services of Kentucky
P.O. Box 2110
Frankfort, KY 40602-2110
Phone: 1-800-635-2570

LOUISIANA

Louisiana Department of Health and Hospitals
P.O. Box 91278
Baton Rouge, LA 70821-9278
Phone: 1-225-342-9500

MARYLAND

Department of Health and Mental Hygiene
P.O. Box 17259
Baltimore, MD 21203-7529
Phone: 1-800-492-5231

OHIO

Department of Job and Family Services of Ohio
30 East Broad Street, 31st Floor
Columbus, OH 43215-3414
Phone: 1-800-324-8680
Social Security Administration.
The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors’ benefits; and benefits for the aged, blind, and disabled. If you have questions about any of these benefits you can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

Railroad Retirement Board.
If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 1-312-751-4701. You can also visit www.rrb.gov.

Employer (or “Group”) Coverage.
If you get your benefits from your current or former employer, or your spouse’s current or former employer, call the employer’s benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

State Pharmacy Assistance Program.
Some states have State Pharmacy Assistance Programs (SPAPs). SPAPs are state-funded programs that provide financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. SPAPs may help pay for the premiums, and/or copayments/coinsurance for those who qualify. Please contact a SPAP in your state to determine what benefits are available to you.

ALABAMA
Senior Rx
Phone: 1-800-AGE-LINE

DELAWARE
Delaware Prescription Assistance
Phone: 1-800-996-9969 ext.17

FLORIDA
SilverSaveRx
Phone: 1-888-419-3456

INDIANA
HoosierRx
Phone: 1-866-267-4679
MARYLAND
Maryland Pharmacy Program
Phone: 1-800-226-2142

OHIO
Golden Buckeye Prescription Drug Savings Program
Phone: 1-866-301-6446
WHAT IS AMERIHEALTH ADVANTAGE?

AmeriHealth Advantage is offered by QCC Insurance Company, and is a Medicare Prescription Drug Plan. Now that you are enrolled in our Plan, you are getting your Medicare Prescription Drug Coverage through QCC Insurance Company. This Evidence of Coverage explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare prescription drug coverage.

Medicare Prescription Drug Coverage is insurance that helps pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Plan network pharmacy, and other coverage rules are followed. We do not pay for drugs that are covered by Medicare Part B. As a member, all you have to do is continue to pay your monthly premium and pay applicable deductibles, copays, and coinsurances. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. If you have limited income and resources, you may get extra help from Medicare to pay your premium, deductible, copayments, and coinsurances so that you get your prescription drugs for little or no cost. Please see Section 2 or call the Member Services Department to learn more.
Help us keep your membership record up-to-date.

We have a file of information about you as a Plan member. Pharmacists use this membership record to know what drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 8 tells you how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting the Member Services Department know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell the Member Services Department about any changes in prescription drug coverage you have from other sources, such as from Medicaid or from your current or former employer, or your spouse's current or former employer. In addition, you should tell the Member Services Department about any changes in coverage due to claims filed under liability insurance, such as workers' compensation claims or claims against another driver in an automobile accident.

WHAT IS THE GEOGRAPHIC SERVICE AREA FOR OUR PLAN?

The states in our service area are listed below.

Alabama, Delaware, District of Columbia, Florida, Georgia, Indiana, Kentucky, Louisiana, Maryland, Ohio, and Tennessee.

USE YOUR PLAN MEMBERSHIP CARD INSTEAD OF YOUR RED, WHITE, AND BLUE MEDICARE CARD

Now that you are a member of our Plan, you have a Plan membership card. Here is a sample card to show what it looks like:

![Sample Membership Card]

- **Member:** Prescription drugs must be obtained from a network pharmacy to receive plan benefits.
- **Please present this card at the time of service with every prescription.**
- **Medicare charge limitations may apply.**
- **To locate participating pharmacy please call:** 1-888-457-3007.

**Member Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTY/TDD</td>
<td>1-888-457-3002</td>
</tr>
<tr>
<td>Provider</td>
<td>1-866-369-6037</td>
</tr>
</tbody>
</table>

**AmeriHealth Advantage**

PO Box 41535
Philadelphia, PA 19101-1535

www.amerihealthpdp.com

Benefits underwritten by QCC Insurance Company
During the time you are a Plan member and using Plan services, you must use your Plan membership card at network pharmacies. Please carry your Plan membership card with you at all times. You will need to show this card in order to get your prescription drugs paid for. If your membership card is ever damaged, lost, or stolen, call the Member Services Department right away and we will send you a new card.

**USING PLAN PHARMACIES TO GET YOUR PRESCRIPTION DRUGS COVERED BY US**

**What are network pharmacies?**

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

- **What is a “network pharmacy”?** A network pharmacy is a pharmacy at which you can get your 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. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies.

- **What are “covered drugs”?** “Covered drugs” is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the Formulary.

**How do I 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 do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can 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 at the end of this section.

**The Pharmacy Directory gives you a list of Plan network pharmacies.**

As a member of our Plan, we will send you a Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find a network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from the Member Services Department. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our website.

**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 the Member Services Department to find another network pharmacy in your area.

**FILLING PRESCRIPTIONS OUTSIDE THE NETWORK**

Generally, we only cover drugs filled at an out-of-network pharmacy in limited 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 the Member Services Department to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you...
qualify for catastrophic coverage (see Section 4). To learn how to submit a paper claim, please refer to the paper claims process described next.

In 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 of 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.

**HOW DO I SUBMIT A PAPER CLAIM?**

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. When you return home, simply submit your claim and your receipt to the following address: Perform Rx, P.O. Box 516, Essington, PA 19029. Upon receipt, we will make an initial coverage determination on the claim.

**SPECIALTY PHARMACIES**

**Home infusion pharmacies.**

Our Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your infused drug(s) from a Plan network pharmacy.

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

**Long-term care pharmacies.**

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the Plan's network of long-term care pharmacies. In some cases the long-term care pharmacy will be the long-term pharmacy that contracts directly with the long-term care facility. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact the Member Services Department.

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

Native Americans and Alaska Natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies through the Plan's pharmacy network. Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact the Member Services Department.
SOME VACCINES AND DRUGS MAY BE ADMINISTERED IN YOUR DOCTOR’S OFFICE

We cover vaccines that are medically necessary and are covered by our Plan but are not already covered by Medicare Part B. In addition we cover some drugs that may be administered in your doctor’s office. (Please see Section 4, “How does your enrollment in the Plan affect coverage for drugs covered under Medicare Part A or Part B?” for more information.)
SECTION 2—EXTRA HELP WITH DRUG PLAN COSTS FOR PEOPLE WITH LIMITED INCOME AND RESOURCES

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Do you qualify for extra help? ..............................................................................................................16
How do I apply for extra help? ...........................................................................................................16
How do I get more information? .........................................................................................................16

WHAT EXTRA HELP IS AVAILABLE?

Starting January 1, 2006, Medicare Prescription Drug Coverage will be available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug costs. If you qualify, you will get help paying for your drug Plan’s monthly premium, yearly deductible, and prescription copayments and coinsurance.

DO YOU QUALIFY FOR EXTRA HELP?

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below $14,355 (or $19,245 if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,500 (or $23,000 if you are married). The amount of extra help you get will depend on your income and resources.

Note: Amounts shown above are for 2005. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call the Member Services Department to find out what the income limits are.

Some people automatically qualify for extra help and do not have to apply for it. If you answer “yes” to any of the questions below, you automatically qualify for extra help:

• Do you have Medicare and full coverage from a state Medicaid?
• Do you get Supplemental Security Income?
• Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

HOW DO I APPLY FOR EXTRA HELP?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

HOW DO I GET MORE INFORMATION?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the web.
TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 Medicare & You Handbook, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Member Services Department, numbers listed on the cover and in the Introduction section. Or, visit our website.
SECTION 3—MONTHLY PREMIUM

Paying the Plan premium for your coverage as a member of our Plan ..................................................18

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Can your Plan Premiums change during the year? ............................................................................19

Do you have to continue to pay your Part A or Part B premiums? .....................................................20

What is the late enrollment penalty? ................................................................................................20

Please Note: If you are receiving extra help with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your Evidence of Coverage Rider. Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP to determine what benefits are available to you.

PAYING THE PLAN PREMIUM FOR YOUR COVERAGE AS A MEMBER OF OUR PLAN

How much is your monthly Plan premium and how do you pay it?

The table below shows the monthly premium amount for each region we serve.

<table>
<thead>
<tr>
<th>Regional Area</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware, Maryland, District of Columbia</td>
<td>$23.16</td>
</tr>
<tr>
<td>Georgia</td>
<td>$23.85</td>
</tr>
<tr>
<td>Florida</td>
<td>$22.58</td>
</tr>
<tr>
<td>Alabama and Tennessee</td>
<td>$25.68</td>
</tr>
<tr>
<td>Ohio</td>
<td>$22.14</td>
</tr>
<tr>
<td>Indiana and Kentucky</td>
<td>$24.34</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$25.02</td>
</tr>
</tbody>
</table>

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.

There are two ways to pay your monthly Plan premium.

Option one: Pay your Plan premium directly to our Plan.

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

- Direct Pay – Your monthly premium bill is sent to your home, you write the check and send it directly to us.
If you are interested in the ZipCheck option, simply complete the enclosed form or call the Member Services Department telephone number listed on the front of this booklet.

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

• You will receive a bill around the 15th of every month.

• Your premium due date is noted on your bill.

• Your bank may apply a penalty to your account if your check should bounce due to insufficient funds.

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

If you prefer, you can also have your premium automatically withdrawn from your bank account or charged directly to your debit card.

Option two: You can have your monthly Plan premium directly deducted from your monthly Social Security check. You can choose this option if you can pay for the entire Medicare premium with your Social Security check. Contact the Member Services Department for more information on how to pay your premium this way.

If you have any questions about your Plan premiums or the different ways to pay them, please call our Member Services Department listed on the cover and in the Introduction section.

WHAT HAPPENS IF YOU DON'T PAY YOUR PLAN PREMIUMS, OR DON'T PAY THEM ON TIME?

If your plan premiums are past due, we will tell you in writing when a 90-day grace period begins. Failure to pay your past-due plan premiums within the 90-day grace period will result in your disenrollment. Disenrollment ends your membership in our Plan. If you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Election Period, unless you qualify for a Special Enrollment Period. If you do not qualify for a Special Enrollment Period or have another source of creditable prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.

If you should decide to re-enroll in this Plan during the next Annual Coordinated Election Period, or to enroll in another Plan offered by QCC Insurance Company, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in our Plan.

Please see Section 7 or call the Member Services Department to find out more about enrollment periods.

CAN YOUR PLAN PREMIUMS CHANGE DURING THE YEAR?

Generally, your Plan premium cannot change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your Plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1, 2007.

In limited circumstances, your Plan premium may change during the calendar year. If you aren't currently receiving extra help but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your Plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or
resources or if you get married or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. The Social Security Administration or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help.

**DO YOU HAVE TO CONTINUE TO PAY YOUR PART A OR PART B PREMIUMS?**

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

Some members who belong to a Medicare Savings Program (Qualified Medicare Beneficiary or QMB, Specified Low-Income Medicare Beneficiary or SLMB, Qualified Individual or QI) may be eligible to get extra help in paying for the cost of their Medicare Part A and/or Part B premiums. Please see Section 2 or call the Member Services Department for more information.

**WHAT IS THE LATE ENROLLMENT PENALTY?**

You will have to pay a late enrollment penalty in addition to your monthly plan premium if you do not enroll in a Medicare Prescription Drug Plan during your initial enrollment period and you do not have *creditable coverage* for a continuous period of at least 63 days after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare Prescription Drug Coverage. You pay this late enrollment penalty for as long as you have Medicare Prescription Drug Coverage. The amount of the late enrollment penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. If you get extra help, your penalty amount may be lower than it is for those who don't qualify. In addition, you may only have to pay the penalty for a maximum of 60 months.
SECTION 4—PRESCRIPTION DRUG COVERAGE

WHAT DRUGS ARE COVERED BY THIS PLAN?

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 4.
The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both Brand-Name drugs and Generic drugs are included on the formulary. A Generic drug has the same active-ingredient formula as the Brand-Name drug. Generic drugs usually cost less than Brand-Name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as Brand-Name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See “Drug Exclusions”, later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 1 (“Plan Basics”) for more information about filling prescription at out-of-network pharmacies.

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

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

**Can the formulary change?**

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60 day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60-days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

**What if your drug is not on the formulary?**

If your prescription is not listed on the formulary, you should first contact the Member Services Department to be sure it is not covered.

If the Member Services Department confirms that we do not cover your drug, you have three options:

- You can 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 the Member Services Department.

- You can ask us to make an exception to cover your drug. See Section 6 to learn more about how to request an exception.

- You can pay out-of-pocket for the drug and request that the Plan reimburse you by requesting a formulary exception. This does not obligate the Plan to reimburse you if the exception request is not approved. See Section 6 for more information on how to request an appeal.

If you recently joined this Plan and learn that we do not cover a drug you were taking when you joined our plan, you may be able to get a one-time fill of that prescription. You can get a one-time fill of the non-covered drug if one of the following applies:

- You didn’t know that your drug wasn’t covered by this Plan, or
• You knew it wasn’t covered but you didn’t know that you could request an exception to the Plan’s formulary.

After your one-time fill, you can ask the Member Services Department if we cover another drug to treat your medical condition. If we cover another drug, you can ask your doctor if this drug is an option for your treatment. You can also file a request for an exception to our formulary. See Section 6 to learn more about how to request an exception.

We use the first fill, but use a 15 day supply instead of a month.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that may be used to treat similar conditions so you can ask your doctor if any of these drugs are an option for your treatment.

While we are helping you to find a covered drug, you may get a 15 day supply if your drug is not on the formulary to make sure that you don’t run out of your medicine.

**Drug exclusions.**

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs or categories of drugs are called “exclusions” and include:

<table>
<thead>
<tr>
<th>Nonprescription drugs, unless they are part of an approved step therapy</th>
<th>Drugs when used for anorexia, weight loss, or weight gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs when used to promote fertility</td>
<td>Drugs when used for cosmetic purposes or hair growth</td>
</tr>
<tr>
<td>Drugs when used for the symptomatic relief of cough or colds</td>
<td>Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations</td>
</tr>
<tr>
<td>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</td>
<td>Barbiturates and Benzodiazepines</td>
</tr>
</tbody>
</table>

In addition, a Medicare Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B. See “How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?” below.

**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 pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our members. Examples of utilization management tools are described below:

• **Prior Authorization:** We require you to get prior authorization for certain drugs. This means that members will need to get approval from us before you fill your prescription. If they don’t get approval, we may not cover the drug.
• **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 9 tablets per prescription for Immitrex.

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

• **Generic Substitution:** When there is a generic version of a Brand-Name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the Brand-Name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. See the section, “How do I request an exception to the formulary?” described above for more information.

**Drug utilization review.**

We conduct drug utilization reviews for all of our members to make sure that they are receiving 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 for members who have multiple medical conditions, who are taking many prescription drugs, or 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 offer several medication therapy management programs for members that meet specific criteria. 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 do not 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 does not 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 is covered by Medicare Part A or Part B, it cannot 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.

**HOW MUCH DO YOU PAY FOR DRUGS COVERED BY THIS PLAN?**

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. See Section 2 “Extra Help with Drug Plan Costs for People with Limited Income and Resources” and the “Evidence of Coverage Rider” for those who get extra help paying for their prescription drugs for more information.

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 level, 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. Your drug costs for each coverage level are described below.

**Deductible.**

You, or others on your behalf, will pay a yearly deductible of $250. This is the amount that must be paid each year before we begin paying for part of your drug costs. After you meet the deductible of $250, you will reach the initial coverage level.

You will pay a yearly deductible of $250 on Generic, Preferred Brand, and Non-Preferred Brand drugs.

**Initial Coverage Level.**

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

<table>
<thead>
<tr>
<th>Drug Tier</th>
<th>Retail Copayment/ Coinsurance (30-day Supply)</th>
<th>Retail Copayment/ Coinsurance (90-day Supply)</th>
<th>Out-of-Network Copayment/ Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>25% Coinsurance</td>
<td>25% Coinsurance</td>
<td>25% Coinsurance</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>25% Coinsurance</td>
<td>25% Coinsurance</td>
<td>25% Coinsurance</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>25% Coinsurance</td>
<td>25% Coinsurance</td>
<td>25% Coinsurance</td>
</tr>
</tbody>
</table>
Once your total drug costs reach $2,250, you will reach your initial coverage level. 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.

Once your total drug costs reach $2,250, you will then reach your initial coverage limit.

**Coverage after you reach your Initial Coverage Limit and before you qualify for Catastrophic Coverage.**

After your total drug costs reach $2,250, you or others on your behalf will pay 100% for your drugs until your total out-of-pocket costs reach $3,600, and 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 $3,600 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 $3,600, you will qualify for catastrophic coverage. During catastrophic coverage you will pay:

The greater of $2 for generics or preferred brand that is a multi-source drug and $5 for all other drugs, or 5% coinsurance. We will pay the rest.

**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 can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug is normally covered by a Medicare Prescription Drug Plan, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), and it was obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy):

- Your annual deductible
- Your coinsurance or copayments made on drugs normally covered in a Medicare Prescription Drug Plan that are:
  - Covered by the Plan up to the initial coverage level,
  - Not on our Plan’s formulary, but were determined to count towards your out-of-pocket costs through the coverage determination, exceptions, or appeals process; and
  - Filled at an out-of-network pharmacy in accordance with our Plan’s out-of-network access rules.
- Any payments you make after the initial coverage limit for drugs.

When you have spent a total of $3,600 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium does not count toward reaching the catastrophic coverage level.

Purchases that will not count toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan.
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 prescription drugs normally covered by a Medicare Prescription Drug Plan 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 prescription drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

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

Payments made by the following do not count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g. TRICARE the Indian Health Service); 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 that pays a part of or all of your out-of-pocket costs, you must disclose this information to us. An example of third party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our Plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

EXPLANATION OF BENEFITS

What is the Explanation of Benefits?

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

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;
• A summary of your coverage this year, including information about:

  • **Annual Deductible**—the amount you pay, and/or others before you start receiving prescription coverage.
  
  • **Amount Paid For Prescriptions**—the amounts paid that count towards your initial coverage limit.
  
  • **Out-Of-Pocket Payments After You Reach the Initial Coverage Limit**—the amount you and/or others make after you reach the initial coverage limit and before you qualify for Catastrophic Coverage.
  
  • **Total Out-Of-Pocket Costs That Count Towards 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, copayments and coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.)

**When will you get your Explanation of Benefits?**

You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us.

**What should you do if you did not get an Explanation of Benefits or if you wish to request one?**

An Explanation of Benefits is also available upon request. To get a copy, please contact the Member Services Department.

**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 will 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 they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

**If you are admitted to a skilled nursing facility for a Medicare-covered stay:** After Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the skilled nursing facility's pharmacy is in our pharmacy network and the drug is not covered by Medicare Part B coverage. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process. When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. Please see Section 7 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.
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We will send you a COB Survey so that we can know what other drug coverage you have in addition to the coverage you get through this Plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call the Member Services Department to update your membership records.

IF YOU HAVE MEDICARE AND MEDICAID

Beginning January 1, 2006, your prescription drug coverage will change. Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid.

IF YOU ARE A MEMBER OF A STATE PHARMACY ASSISTANCE PROGRAM (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your premiums, and/or copayments. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction for more information.

IF YOU HAVE A MEDIGAP POLICY WITH PRESCRIPTION DRUG COVERAGE

If you currently have a Medicare Supplement (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 policy and adjust your premium. In addition, under certain circumstances, you may be able to purchase a different Medigap policy from the same company. Your Medigap issuer cannot charge you more based on any past or present health problems.

In the fall of 2005, your Medigap issuer sent a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you did not get this letter, please contact your Medigap issuer.

IF YOU ARE A MEMBER OF AN EMPLOYER OR RETIREE GROUP

If you currently have prescription drug coverage through your 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.
In the fall of 2005 your employer or retiree group sent a letter that indicated whether or not your prescription drug coverage is *creditable* (meaning whether or not it covers at least as much as Medicare’s prescription drug plan coverage) and the options available to you. If you did not get this letter, please contact your benefits administrator.

**IF YOU ARE ENROLLED IN A MEDICARE-APPROVED DRUG DISCOUNT CARD PROGRAM**

If you have a Medicare-approved drug discount card, you may continue to use your card to get discounts on your prescription drugs until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are a member of a Medicare-approved drug discount card and are receiving up to $600 credit in help paying for your prescription drugs, you will be able to use any remaining credit you have towards your prescription drug purchases until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

**IF YOU ARE ENROLLED IN A NON-MEDICARE APPROVED DRUG DISCOUNT CARD PROGRAM**

If you are a member of a drug discount card program that is not Medicare-approved, please contact your drug card issuer to determine what benefits are available to you. Any amount you pay while using a discount card for drugs normally covered by Medicare prescription drug Plans and covered by us can count towards your out-of-pocket expenses. Please submit claims to: AmeriHealth Advantage, P.O. Box 516, Essington, PA 19029.
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WHAT TO DO IF YOU HAVE COMPLAINTS

Introduction.

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call our Member Services Department numbers listed on the cover.

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

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations, and appeals.

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations include exception requests. You have the right to ask us for an “exception” if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request an exception, your doctor must provide a statement to support your request.

You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.
What is an appeal?
An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

How to file a grievance.
This part of Section 6 explains how to file a grievance. A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below).

What types of problems might lead to you filing a grievance?
• You feel that you are being encouraged to leave (disenroll from) our Plan.
• Problems with the Member Services Department you receive.
• Problems with how long you have to spend waiting on the phone or in the pharmacy.
• Disrespectful or rude behavior by pharmacists or other staff.
• Cleanliness or condition of pharmacy.
• If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.
• You believe our notices and other written materials are difficult to understand.
• Failure to give you a decision within the required timeframe.
• Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
• Failure by the Plan sponsor to provide required notices.
• Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

If you have a grievance, we encourage you to first call the Member Services Department at the number listed on the cover. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, 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 this formal grievance/complaint procedure, submit your grievance in writing to: Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652. We will write you to let you know that we have received and investigated your concern within 30 days of receiving your grievance. We are required to track all appeals and grievances in order to report cumulative data to CMS and to our members, upon request.
EXPEDITED GRIEVANCE PROCESS
As a member you can file an expedited grievance with our Plan for the following reasons:

• Our decision to invoke an extension to the organization determination or reconsideration time frames.
• Our refusal to grant a member’s request for an expedited organization determination or reconsideration.

We must respond within 24 hours of receiving your expedited grievance request. To file an expedited grievance, please call 1-888-457-3007 or mail a written request to Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional Information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO).

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare prescription drug plan under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the Part D Plan’s grievance process. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint.

How to file a quality of care complaint with the QIO.
Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See the Introduction for more information about how to file a quality of care complaint with the QIO.

How to request a coverage determination.
This part of Section 6 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word “provide” in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that we will not cover a prescription drug, you should contact us and ask for a coverage determination. The following are examples of when you may want to ask us for a coverage determination:

• If you are not getting a prescription drug that you believe may be covered by us.
• If you have received a Part D prescription drug you believe may be covered by us while you were a member, but we have refused to pay for the drug.
• If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a “formulary”). You can request an exception to our formulary.
• If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the copayment we require you to pay for a drug.

• If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.

• If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.

• If there is a requirement that you try another drug before we will pay for the drug you are requesting.

• You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

• The process for requesting a coverage determination is discussed in greater detail below in the section titled “Detailed information about how to request a coverage determination and an appeal”.

How to request an appeal.
This part of Section 6 explains what you can do if you disagree with our coverage determination. If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

What kinds of decisions can be appealed?
• You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request described in Section 4 of this document, you can appeal. A coverage determination, which includes those described on page 36, may be appealed if you disagree with our decision.

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

How does the appeals process work?
There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

• Moving from one level to the next. At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

• Who makes the decision at each level. You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome,
you can ask for further review. If you ask for further review, your appeal is then sent outside of this Plan, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the Federal court system. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail below in the section titled “Detailed information about how to request a coverage determination and an appeal.”

**DETAILED INFORMATION ABOUT HOW TO REQUEST A COVERAGE DETERMINATION AND AN APPEAL**

**What is the purpose of this section?**

The purpose of this section is to give you more information about how to request a coverage determination, or appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

**COVERAGE DETERMINATIONS: OUR PLAN MAKES A COVERAGE DETERMINATION ABOUT YOUR PART D PRESCRIPTION DRUG, OR ABOUT PAYING FOR A PART D DRUG YOU HAVE ALREADY RECEIVED.**

**What is a coverage determination?**

The coverage determination made by our Plan is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered you should contact our Plan and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request (this is sometimes called an “adverse coverage determination”), you can “appeal” our decision by going on to Appeal Level 1 (see page 39). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 page 41).

The following are examples of coverage determinations:

- You ask us to pay for a drug you have already received. This is a request for a coverage determination about payment. You can call the Member Services Department to get help in making this request.

- You ask for a Part D drug that is not on your Plan’s list of covered drugs (called a “formulary”). This is a request for a “formulary exception.” You can refer to our Member Services Department to ask for this type of decision.

- You ask for an exception to our Plan’s utilization management tools. Requesting an exception to a utilization management tool is a type of formulary exception. You can call the Member Services Department to ask for this type of decision.

- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a “tiering exception.” You can refer to our Member Services Department to ask for this type of decision.

- You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a doctor’s office, will be covered by the plan. See Section 1 for a description of these circumstances. You can refer to our
Member Services Department to make a request for payment or coverage for drugs provided by an
out-of-network pharmacy or in a doctor’s office.

When we make a coverage determination, we are giving our interpretation of how the Part D
prescription drug benefits that are covered for members of our Plan apply to your specific
situation. This document and any amendments you may receive describe the Part D prescription drug
benefits covered by our Plan, including any limitations that may apply to these benefits. This Evidence
of Coverage also lists exclusions (benefits that are “not covered” by our Plan).

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing doctor or someone you
name may do it for you. The person you name would be your appointed representative. You can name
a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be
authorized under State law to act for you. If you want someone to act for you, then you and that
person must sign and date a statement that gives the person legal permission to act as your appointed
representative. This statement must be sent to us at: Medicare Member Appeals Unit, P.O. Box 13652,
Philadelphia, PA 19101-3652. You can call the Member Services Department to learn how to name your
appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can
contact your own lawyer, or get the name of a lawyer from your local bar association or other referral
service. There are also groups that will give you free legal services if you qualify.

ASKING FOR A “STANDARD” OR “FAST” COVERAGE DETERMINATION

Do you have a request for a Part D prescription drug that needs to be decided more quickly than
the standard timeframe?

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

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

Asking for a standard decision.

To ask for a standard decision, you, your doctor, or your appointed representative should refer to our
Member Services Department numbers listed on the cover and in the Introduction section for assistance.
Or, you can deliver a written request to the address listed in the Introduction, or fax it to
1-888-289-3008.

Asking for a fast decision.

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a
standard decision) by calling our Member Services Department numbers listed on the cover and in the
Introduction section. Or, you can deliver a written request to the address listed in the introduction, or fax
it to 215-988-2001. Be sure to ask for a “fast,” “expedited,” or “24-hour” review.
• If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

• If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard timeframe.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.

Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules — such as dosage or quantity limits or step therapy requirements), we must make our decision no later than 72 hours after we have received your doctor’s “supporting statement,” which explains why the drug you are asking for is medically necessary. If you are requesting an exception, you should submit your prescribing doctor’s supporting statement with the request, if possible.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section “Appeal Level 1” explains how to file this appeal.

If we have not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

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

If you get a fast review, we will give you our decision within 24 hours after you or your doctor asks for a fast review — sooner if your health requires. If your request involves a request for an exception, we must make our decision no later than 24 hours after we get your doctor’s “supporting statement,” which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision, under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section “Appeal Level 1” explains how to file this appeal.

If we decide you are eligible for a fast review, and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.
If we do not grant your or your doctor’s request for a fast review, we will give you our decision within the standard 72-hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor’s support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.

   We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we get your doctor’s “supporting statement.” If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we get the request.

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

   We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we get your doctor’s “supporting statement.”

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide completely or only partly against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you all that you requested, you have the right to appeal the decision. (See Appeal Level 1).

APPEAL LEVEL 1: IF WE DENY ALL OR PART OF YOUR REQUEST IN OUR COVERAGE DETERMINATION, YOU MAY ASK US TO RECONSIDER OUR DECISION. THIS IS CALLED AN “APPEAL” OR “REQUEST FOR REDETERMINATION.”

Please call the Member Services Department if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we get your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast appeal are the same as those described for
a standard or fast *coverage determination*. Please see the discussion under “Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?” and “Asking for a fast decision.”

**Getting information to support your appeal.**

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to get 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 can give us your additional information in any of the following ways:

- In writing to the, Medicare Member Appeals Unit, P.O. Box 13652, Philadelphia, PA 19101-3652
- By fax, at 1-888-289-3008
- By telephone – if it is a fast appeal – at 1-888-457-3007
- In person, at 1901 Market Street, 1st Floor, Philadelphia, PA 19103

You also have the right to ask us for a copy of information regarding your appeal. You can call at 1-888-457-3007, or write us at Medicare Member Appeals Unit, P.O. Box 13652, Philadelphia, PA 19101-3652. We are allowed to charge a fee for copying and sending this information to you.

**Who may file your appeal of the coverage determination?**

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing doctor.

**How soon must you file your appeal?**

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can call the Member Services Department or you can send the appeal to us in writing at Medicare Member Appeals Unit, P.O. Box 13652, Philadelphia, PA 19101-3652.

**What if you want a fast appeal?**

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling our Member Services Department numbers listed on the cover and in the Introduction section. Or, you can deliver a written request to, the address listed in the Introduction, or fax it to 1-215-988-2001. Be sure to ask for a “fast,” “expedited,” or “72-hour” review. Remember that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.
How soon must we decide on your appeal?
How quickly we decide on your appeal depends on the type of appeal:

1. For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.

   After we get your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will automatically go to the second level of appeal, where an independent organization will review your case.

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

   After we get your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. For a decision about reimbursement for a Part D drug you already paid for and received.

   We must send payment to you no later than 30 calendar days after we get your request to reconsider our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

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

   We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal — or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?
If we deny any part of your appeal, you or your appointed representative has the right to ask an independent organization, to review your case. This independent review organization contracts with the Federal government and is not part of our Plan.

**APPEAL LEVEL 2: IF WE DENY ANY PART OF YOUR FIRST APPEAL, YOU MAY ASK FOR A REVIEW BY A GOVERNMENT-CONTRACTED INDEPENDENT REVIEW ORGANIZATION**

What Independent Review Organization does this review?
At the second level of appeal, your appeal is reviewed by an outside, Independent Review Organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The Independent Review Organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.
How soon must you file your appeal?
You or your appointed representative must make a request for review by the Independent Review Organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the Independent Review Organization whose name and address is included in the redetermination notice you get from us.

What if you want a fast appeal?
The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing doctor cannot file the request for you – only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under “Asking for a fast decision.” Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, the IRO will automatically treat you as eligible for a fast appeal.

How soon must the Independent Review Organization decide?
After the Independent Review Organization gets your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the Independent Review Organization has up to 7 calendar days from the date it gets your request to give you a decision.

2. For a fast decision about a Part D drug that you have not received, the Independent Review Organization has up to 72 hours from the time it gets the request to give you a decision.

If the Independent Review Organization decides completely in your favor:
The Independent Review Organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. For a decision about reimbursement for a Part D drug you already paid for and received.
   We must pay within 30 calendar days from the date we get notice reversing our coverage determination. We will also send the Independent Review Organization a notice that we have abided by their decision.

2. For a standard decision about a Part D drug you have not received.
   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination. We will also send the Independent Review Organization a notice that we have abided by their decision.

3. For a fast decision about a Part D drug you have not received.
   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination. We will also send the Independent Review Organization a notice that we have abided by their decision.
What happens next if the review organization decides against you (either partly or completely)?

The Independent Review Organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is $110 or more.

APPEAL LEVEL 3: IF THE ORGANIZATION THAT REVIEWS YOUR CASE IN APPEAL LEVEL 2 DOES NOT RULE COMPLETELY IN YOUR FAVOR, YOU MAY ASK FOR A REVIEW BY AN ADMINISTRATIVE LAW JUDGE

As stated above, if the Independent Review Organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to: MAXIMUS, 1040 First Avenue, Suite 200, King of Prussia, PA 19406.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than $110. If the dollar value is less than $110, you may not appeal any further.

How is the dollar value (the “amount remaining in controversy”) calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your copayments, all costs incurred after your costs exceed the initial coverage limit, and costs paid by other entities.

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

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the Independent Review Organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.
If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. For a decision about payment for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

APPEAL LEVEL 4: YOUR CASE MAY BE REVIEWED BY THE MEDICARE APPEALS COUNCIL

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. For a decision about payment for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.
3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

**If the Council decides against you:**

If the amount involved is $1,090 or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than $1,090, the Council’s decision is final and you may not take the appeal any further.

**APPEAL LEVEL 5: YOUR CASE MAY GO TO A FEDERAL COURT**

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

If the contested amount is $1,090 or more, you may ask a Federal Court Judge to review the case.

**How soon will the Judge make a decision?**

The Federal judiciary is in control of the timing of any decision.

**If the Judge decides in your favor:**

Once we get notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. **For a decision about payment for a Part D drug you already received.**

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

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

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

**If the Judge decides against you:**

The Judge’s decision is final and you may not take the appeal any further.
**SECTION 7—LEAVING THIS PLAN AND YOUR CHOICES FOR CONTINUING PRESCRIPTION DRUG COVERAGE AFTER YOU LEAVE**

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**WHAT IS “DISENROLLMENT”?**

“Disenrollment” from our Plan means ending your membership with us. **Disenrollment can be voluntary (your own choice) or, in limited circumstances, involuntary (not your own choice):**

- You might leave our Plan because you have decided that you want to leave. You can decide to leave for any reason during specified times (See “When Can You Disenroll/Switch Prescription Drug Plans?” below).

- There are also a few situations where you would be required to leave. For example, you would have to leave our Plan if you move out of our geographic service area or if we no longer offer prescription drug coverage in your geographic area. We are not allowed to ask you to leave our Plan because of your health.

Whether leaving our Plan is your choice or not, this section explains your prescription drug coverage choices after you leave and the rules that apply.

**UNTIL YOUR PRESCRIPTION DRUG COVERAGE WITH OUR PLAN ENDS, USE OUR NETWORK PHARMACIES TO FILL YOUR RX**

If you leave our Plan, it takes some time for your prescription drug coverage to end and your new prescription drug coverage to begin (we discuss when the change takes effect later in this section). You can choose to disenroll from your current plan from November 15 through December 31 of every year. Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can disenroll from your plan at other times. After you request to disenroll, your Plan will let you know, in writing, the date your coverage ends. If you don’t get a letter, call the Plan and ask for the date.
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 or through our mail order pharmacy service, are listed on our formulary, and you follow other coverage rules.

If you have any questions about your prescription drug coverage with our Plan, please refer to our Member Services Department numbers listed on the cover and in the Introduction Section.

**WHAT ARE YOUR OPTIONS FOR GETTING RX DRUG COVERAGE IF YOU LEAVE OUR PLAN?**

If you leave our Plan, one choice for getting prescription drug coverage is to join another Medicare Prescription Drug Plan. You also have the choice of joining a Medicare Advantage Plan or a Medicare Cost Plan with prescription drug coverage if this type of plan is available in your area, they are accepting new members, and you meet the eligibility requirements of the plan.

**Medicare Prescription Drug Plan.** You may choose to join another Prescription Drug Plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another Prescription Drug Plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and reside in the service area of the Prescription Drug Plan. Refer to the next section, “When can you disenroll/switch Medicare Prescription Drug plans” for information on when you can make this change.

**Medicare Advantage Prescription Drug Plan (MA-PD) or Medicare Cost Plan with Prescription Drug Coverage.** If you choose to join a Medicare Advantage Plan that offers prescription drug coverage, then you must get your Medicare Prescription Drug Coverage through that Medicare Advantage Plan. If you choose to join a Medicare Cost Plan that offers prescription drug coverage, you can get your drug coverage either from the Cost Plan or by joining a separate Medicare Prescription Drug Plan. For more information on joining a Medicare Advantage Plan or a Medicare Cost Plan in your area, please contact 1-800-MEDICARE (TTY/TDD users call 1-877-486-2048) or visit www.medicare.gov. Refer to the next section, “When can you disenroll/switch Medicare Prescription Drug Plans” for information on when you can make this change. You should contact the new plan that you are interested in for information on how and when you are able to join it.

You may also be able to get back the prescription drug coverage you had before you enrolled in our Plan. Please contact your previous Prescription Drug Plan for more information.

**Note:** If you disenroll from our Plan and do not enroll in another Medicare Prescription Drug Plan, or have other prescription drug coverage that is at least as good as Medicare prescription drug coverage, you may have to pay a penalty if you enroll in a Medicare Prescription Drug Plan at a later date. Refer to Section 3 for more information on the penalty.

**WHEN CAN YOU DISENROLL/SWITCH MEDICARE PRESCRIPTION DRUG PLANS?**

In general, you may only disenroll or switch prescription drug plans every year during the Annual Coordinated Enrollment Period (see below) or under certain special circumstances. You can switch your Prescription Drug Plan during the following periods:

If you have a Medigap (Medicare Supplement) Policy with prescription drug coverage, you should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and explaining how the removal of drug coverage from your Medigap plan will affect your premiums. If you enroll in a Prescription Drug Plan during the initial enrollment period (November 15, 2005 through May 15, 2006),
you will also be guaranteed the right to switch to a different Medigap plan without drug coverage from the same issuer that sold you your Medigap policy with the drug coverage. If you did not get this letter, contact the issuer of your Medigap policy.

**Annual Coordinated Election Period.**

During the Annual Coordinated Election Period, anyone with prescription drug coverage may disenroll from any Prescription Drug Plan and join another Prescription Drug Plan, or join a Medicare Advantage Plan with prescription drug coverage, or choose not to have any Medicare Prescription Drug Coverage.

For coverage beginning in 2006, the Annual Coordination Election Period begins on November 15, 2005 and ends on May 15, 2006.

For coverage beginning in 2007 and afterwards, the Annual Coordinated Election Period goes from November 15 through December 31 of each year.

Please remember, if during this election period you disenroll from our Plan and do not enroll in another Prescription Drug Plan or Medicare Advantage Plan with prescription drug coverage during this election period, you may have to pay a higher premium for Medicare Prescription Drug Coverage in the future.

If you join another Prescription Drug Plan during the Annual Coordinated Election Period, your enrollment in our Plan will end on December 31 and your enrollment in the new Plan will be effective on January 1st of the following year.

*Exception for January 1, 2006 through May 15, 2006.* If you disenroll from our Plan to join another Prescription Drug Plan between January 1, 2006 and May 15, 2006, your coverage will be effective on the first day of the month after the month in which you join the Plan.

**Special Enrollment Period.**

Generally, you may not disenroll from our Plan and enroll in a new Prescription Drug Plan during other times of the year unless you qualify for a Special Enrollment Period. In order to qualify for a Special Enrollment Period, one of the following must apply to you:

- Our Plan no longer offers prescription drug coverage in the area where you live.
- You move outside our Plan’s service area.
- You have an involuntary loss of creditable prescription drug coverage. Please note that failure to pay your premium does not qualify as an involuntary loss of prescription drug coverage.
- You were not adequately informed about your loss of creditable prescription drug coverage, or you were not adequately informed that you never had creditable prescription drug coverage.
- Your enrollment in our Plan was unintentional, inadvertent, or a mistake, because of the error, misrepresentation or inaction of a Federal employee, or a person acting upon the Federal government’s behalf.
- You get benefits from both Medicare and Medicaid programs or you were eligible for benefits from both Medicare and Medicaid and you lose your Medicaid benefits.
- Our Plan’s contract with the Centers for Medicare & Medicaid Services is terminated.
- You were a member of a Medicare Advantage Plan with prescription drug coverage and decided to
join a Prescription Drug Plan during the Medicare Advantage Plan’s Open Election Period.

- You are able to demonstrate that our Plan has substantially violated a material provision in its contract. This includes, but is not limited to:
  - If our Plan failed to provide you with prescription drug coverage in a timely manner.
  - If our Plan failed to provide your prescription drug coverage with applicable quality standards.
  - You are able to demonstrate that our Plan misrepresented itself in its marketing.
  - You are enrolling in or disenrolling from a Medicare Prescription Drug Plan sponsored by your current or former employer or by your spouse’s current or former employer.
  - In certain cases in which our Plan is sanctioned by the Centers for Medicare & Medicaid Services.
  - You enroll in or disenroll from your state’s Program of All-Inclusive Care for the Elderly.
  - You move into, live in, or move out of certain medical facilities, including a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital or unit, rehabilitation hospital or unit, long-term care hospital, or certain other hospitals.
  - You get extra help and the Centers for Medicare & Medicaid Services enrolled you in your current Plan.

In the event that you are eligible for a Special Enrollment Period, the Centers for Medicare & Medicaid Services will determine the time frame for you to enroll in another Plan. If you feel you qualify for a Special Enrollment Period, please call the Member Services Department and we will assist you.

HOW DO YOU DISENROLL?

If you wish to leave our Plan, and you are not enrolling in another Prescription Drug Plan, you will need to submit a disenrollment request. Your request should include your name, medicare number, Social Security number, date of birth, and requested disenrollment date. (Please note that we may not be able to disenroll you on the date you request.) Please remember to sign and date the request and to include a phone number where we can reach you in case we need additional information. You can mail a letter to us at: Eligibility Verification Department, P.O. Box 41535, Philadelphia, PA 19101-1535, or fax it to us at 215-241-2275.

Or to get a copy of our disenrollment form, please refer to our Member Services Department numbers listed on the cover and in the Introduction section. You may also disenroll by calling 1-800-MEDICARE (1-800-633-4227), TTY/TDD users should call 1-877-486-2048. You may only disenroll during the Annual Coordinated Election Period unless you qualify for a Special Enrollment Period.

If you are joining another Prescription Drug Plan, you must contact that Plan to request enrollment information. Once you are enrolled in your new Plan, your membership in our Plan will automatically end with no action required on your part. Your new Plan will tell you, in writing, the date when your prescription drug coverage in that Plan begins. Your prescription drug coverage with our Plan will end on that same day (this will be your “disenrollment date”). Remember, you are still a member of our Plan until your disenrollment date, and must continue to get your prescription drug coverage, as usual, through our Plan until the date your membership ends.
WHEN CAN OUR PLAN DISENROLL YOU?

Our Plan can disenroll you for the following reasons:

• You are no longer eligible for Medicare Prescription Drug Coverage.

• If our Plan is no longer contracting with Medicare or leaves your service area.

• When you move out of our Plan’s service area.

• You materially misrepresent third-party reimbursement.

• You fail to pay your Plan premium.

• You engage in disruptive behavior, provided fraudulent information when you enrolled or abuse your enrollment card.

If you are no longer eligible for Medicare Prescription Drug Coverage.

If you lose your eligibility for Medicare Prescription Drug Coverage, our Plan can no longer offer you prescription drug coverage. In order to be eligible for prescription drug coverage under Medicare, you must have Part A and/or Part B, and reside in our Plan’s service area.

When our Plan is no longer contracting with Medicare or leaves your service area.

If we leave the Medicare program or no longer offer prescription drug coverage in the service area where you live, we will notify you in writing. If this happens, your membership in our Plan will end, and you will have to enroll in another Medicare Prescription Drug Plan to continue your prescription drug coverage. All of the benefits and rules described in this Evidence of Coverage will continue until your membership ends. This means that you must continue to get your prescription drugs in the usual way through our Plan's network pharmacies until your membership ends.

Your choices include joining another Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage if these plans are available in your area and are accepting new members. Once we have notified you in writing that we are leaving the Medicare program or the area where you live, you may enroll in another plan (See “When Can You Disenroll/Switch Prescription Drug Plans?” above for specific information on special enrollment periods).

Our Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract may be renewed each year. However, our Plan or CMS can decide to end the contract at any time. You will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

When you move out of our Plan’s service area.

If you plan to move, please call our Member Services Department numbers listed on the cover and in the Introduction section to find out if the place you are moving to is in our Plan’s service area. If you move permanently out of our service area, you will need to leave (“disenroll” from) our Plan. An earlier part of this section tells about the choices you have if you leave our Plan and explains how to leave.
You materially misrepresent third-party reimbursement.
If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires our Plan to disenroll you. In addition, if you are disenrolled from our Plan for misrepresentation of third party reimbursement, our Plan has the right to decline you future enrollment in our Prescription Drug Plan.

You fail to pay the Plan premium.
If you fail to pay your Plan premium, our Plan has the right to disenroll you. Our Plan will send you a written notice in an effort to collect the unpaid premium(s). Failure to comply with payment will result in disenrollment from our Plan.

In addition, if you are disenrolled from our Plan for failure to pay your premium, our Plan has the right to decline your future enrollment in our Prescription Drug Plan until your debt has been paid.

If you are disenrolled due to not paying your premium and you do not have drug coverage that, on average, is at least as good as standard Medicare prescription drug coverage for 63 days or longer, then you will pay a penalty the next time you enroll in a Medicare Prescription Drug Plan.

You engage in disruptive behavior, provided fraudulent information when you enrolled, or abuse your enrollment card.
You may be asked to leave our Plan in the following circumstances:

• If you behave in a way that seriously affects our ability to arrange or provide services for you or for others who are members of our Plan. We cannot make you leave (i.e., disenroll from) our Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.

• If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.

• If you let someone else use your Plan membership card to get prescription drugs for themselves or for others. Before we ask you to leave (i.e., disenroll from) our Plan for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.

WE CANNOT ASK YOU TO LEAVE OUR PLAN BECAUSE OF YOUR HEALTH
No member of any Medicare Prescription Drug Plan can be asked to leave the Plan for any health-related reasons or the number of prescriptions a member takes. 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; TTY/TDD 1-877-486-2048), the national Medicare helpline.

YOU HAVE THE RIGHT TO MAKE A COMPLAINT IF WE ASK YOU TO LEAVE OUR PLAN
If we ask you to leave our Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 6 for more information.
SECTION 8—YOUR RIGHTS AND RESPONSIBILITIES AS A MEMBER OF THIS PLAN

INTRODUCTION ABOUT YOUR RIGHTS AND PROTECTIONS
Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a member of this Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

YOUR RIGHT TO BE TREATED WITH FAIRNESS AND RESPECT
You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have.

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. You can also reach the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area.

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If you need help with communication, such as help from a language interpreter, please call our Member Services Department numbers listed on the cover.
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 keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not 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 is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the 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 determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call our Member Services numbers listed on the cover.

YOUR RIGHT TO GET YOUR PRESCRIPTIONS FILLED WITHIN A REASONABLE PERIOD OF TIME

As explained in this Evidence of Coverage, you should get all of your prescriptions filled from a network pharmacy, that is, from pharmacies that contract with our Plan. You have the right to go to any network pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. “Timely access” means that you can get your prescriptions filled within a reasonable amount of time. Section 1 explains how to use a network pharmacy to get your prescriptions filled.

YOUR RIGHT TO KNOW YOUR TREATMENT CHOICES AND PARTICIPATE IN DECISIONS ABOUT YOUR HEALTH CARE

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision. “Initial decisions” are discussed in Section 6.

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. “Appeals” and “grievances” are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and grievances are discussed in Section 6.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that members have filed against us in the past. To get this information, call our Member Services Department numbers listed on the cover.
YOUR RIGHT TO GET INFORMATION ABOUT YOUR DRUG COVERAGE AND COSTS

This Evidence of Coverage tells you what you have to pay for prescription drugs as a member of our Plan. If you need more information, please call our Member Services Department numbers listed on the cover. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 6 for more information about filing an appeal.

YOUR RIGHT TO GET INFORMATION ABOUT OUR PLAN AND OUR NETWORK PHARMACIES

You have the right to get information from us about QCC Insurance Company and AmeriHealth Advantage. This includes information about our financial condition and about our network pharmacies. To get any of this information, call the Member Services Department at the phone number listed on the cover.

HOW TO GET MORE INFORMATION ABOUT YOUR RIGHTS

If you have questions or concerns about your rights and protections, please call our Member Services Department numbers listed on the cover and in the Introduction section. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

WHAT CAN YOU DO IF YOU THINK YOU HAVE BEEN TREATED UNFAIRLY OR YOUR RIGHTS ARE NOT BEING RESPECTED?

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Member Services Department numbers listed on the cover. You can also get help from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state).

WHAT ARE YOUR RESPONSIBILITIES AS A MEMBER OF OUR PLAN?

Along with the rights you have as a member of our Plan, you also have some responsibilities. Your responsibilities include the following:

- Become familiar with your coverage and the rules you must follow to get care as a member. You can use this Evidence of Coverage and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call the Member Services Department at the phone number listed on the cover if you have any questions.

- Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.

- Pay your Plan premiums and any copayments you may owe for the covered drugs you get. You must also meet your other financial responsibilities that are described in Section 3.

- Let us know if you have any questions, concerns, problems, or suggestions. If you do, please call our Member Services Department numbers listed on the cover.
SECTION 9—LEGAL NOTICES

Notice about governing law ................................................................................................................55
Notice about nondiscrimination ..........................................................................................................55

NOTICE ABOUT GOVERNING LAW

Many different laws apply to this Evidence of Coverage. Some parts may apply to your situation
because they are required by law. This can affect your rights and responsibilities even if the laws are
not included or explained in this document. The 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 (CMS). In addition, other Federal laws may apply and, under certain
situations, the laws of the State(s) of Alabama, Delaware, District of Columbia, Florida, Georgia,
Indiana, Kentucky, Louisiana, Maryland, Ohio, or Tennessee may also apply.

NOTICE ABOUT NONDISCRIMINATION

When we make decisions about the provision of health care services, we do not 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 us, 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.
For The Terms Listed Below, this Section either Gives A Definition Or Directs You To a Place In This Evidence of Coverage That Explains The Term

**Appeal**—A type of complaint you make when you want a reconsideration and a change to a decision we have made about what drugs are covered for you or what we will pay for a drug. Section 6 explains what appeals are, including the process involved in making an appeal.

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

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

**Coverage Determination**—The decision the Plan makes about the prescription drug benefits you are entitled to get under the Plan, and the amount that you are required to pay for a drug.

**Covered Drugs**—The general term we use to mean all of the prescription drugs covered by our Plan.

**Creditable Coverage**—Coverage that is at least as good as the standard Medicare Prescription Drug Coverage.

**Disenroll or Disenrollment**—The process of ending your membership in our Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 7 discusses disenrollment.

**Evidence of Coverage and Disclosure Information**—This document, along with your enrollment form and any other attachments, which explains your coverage, defines our obligations, and explains your rights and responsibilities 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 has the same active-ingredient formula as a Brand-Name drug. Generic drugs usually cost less than Brand-Name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as Brand-Name drugs.

**Grievance**—A type of complaint you make about us or one of our Plan’s providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 6 for more information about grievances.
Late Enrollment Penalty—If you do not have creditable prescription drug coverage, you will have to pay a late enrollment penalty in addition to your monthly Plan premium.

Medically Necessary—Services that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

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

Medicare Advantage Plan with Prescription Drug Coverage—A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area.

Medicare Health Plan—A benefit package offered by an insurance company that contracts with Medicare. The plan is available to anyone who lives in the Plan service area and who has Medicare Parts A and B, except those who have End-Stage Renal Disease (unless certain exceptions apply).

Medicare Prescription Drug Coverage—Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

“Medigap” (Medicare supplement insurance) Policy—Many people who receive Original Medicare also buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage.

Member (Member of Plan)—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 Department—A department responsible for answering your questions about your membership, benefits, grievances, and appeals. See the Introduction for information about how to contact the Member Services Department.

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.

Non-Preferred Network Pharmacy—A network pharmacy that offers covered drugs to members of our Plan at higher cost-sharing levels than apply at a preferred network pharmacy.

Out-of-Network Pharmacy—A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

Part D Drugs—Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug unless it is covered under Part A or Part B.
Preferred Network Pharmacy—A network pharmacy that offers covered drugs to members of our Plan at lower cost-sharing levels than apply at another network pharmacy.

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

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