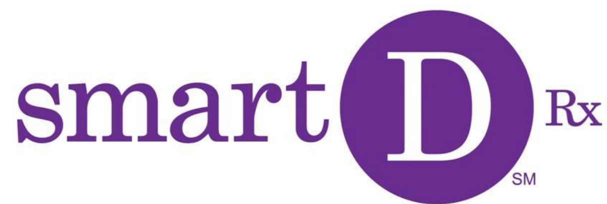


January 1 – December 31, 2013

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of SmartD Rx Saver (PDP)

This booklet gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2013. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, SmartD Rx Saver (PDP), is offered by Smart Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Smart Insurance Company. When it says "plan" or "our plan," it means SmartD Rx Saver (PDP)).

SmartD Rx Saver (PDP) is a stand-alone prescription drug plan with a Medicare contract.

This information is available for free in other languages. Please contact our Member Services number at 1-855-976-2781 for additional information. (TTY users should call 1-888-328-0419. Hours are 24 hours a day, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.

Esta información está disponible de manera gratuita en otros idiomas. Llame a nuestro número del Departamento de atención a afiliados, el 1-855-976-2781, para recibir información adicional. (Los usuarios de TTY deberán llamar al 1-888-328-0419). El horario de atención es de 24 horas, los 7 días de la semana. El Departamento de atención a afiliados también cuenta con servicios de intérprete gratuitos disponibles para personas que no hablen inglés.

This document is available in different formats including large print. Please call 1-855-976-2781 (TTY users: 1-888-328-0419), 24 hours a day, 7 days a week if you need plan information in another format.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2014.

S0064_601190005_EOCS CMS Accepted

2013 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member ... 1

Explains what it means to be in a Medicare prescription drug plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.

Chapter 2. Important phone numbers and resources ... 13

Tells you how to get in touch with our plan (SmartD Rx Saver (PDP)) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

Chapter 3. Using the plan's coverage for your Part D prescription drugs ... 25

Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan's *List of Covered Drugs (Formulary)* to find out which drugs are covered. Tells which kinds of drugs are *not* covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan's programs for drug safety and managing medications.

Chapter 4. What you pay for your Part D prescription drugs ... 44

Tells about the 4 stages of drug coverage (Deductible Stage, Initial Coverage Period, Coverage Gap Stage, Catastrophic Coverage Stage) and how these stages affect what you pay for your drugs. Explains the 5 cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier. Tells about the late enrollment penalty.

Chapter 5. Asking us to pay our share of the costs for covered drugs 67

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered drugs.

Chapter 6. Your rights and responsibilities 73

Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints) 82

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules and/or extra restrictions on your coverage.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

Chapter 8. Ending your membership in the plan 107

Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.

Chapter 9. Legal notices 116

Includes notices about governing law and about nondiscrimination.

Chapter 10. Definitions of important words 118

Explains key terms used in this booklet.

Chapter 1. Getting started as a member

SECTION 1 Introduction 3

Section 1.1 You are enrolled in SmartD Rx Saver (PDP), which is a Medicare Prescription Drug Plan 3

Section 1.2 What is the Evidence of Coverage booklet about? 3

Section 1.3 What does this Chapter tell you? 3

Section 1.4 What if you are new to SmartD Rx Saver (PDP)? 3

Section 1.5 Legal information about the Evidence of Coverage 4

SECTION 2 What makes you eligible to be a plan member? 4

Section 2.1 Your eligibility requirements 4

Section 2.2 What are Medicare Part A and Medicare Part B? 4

Section 2.3 Here is the plan service area for SmartD Rx Saver (PDP) 5

SECTION 3 What other materials will you get from us? 5

Section 3.1 Your plan membership card – Use it to get all covered prescription drugs 5

Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network 6

Section 3.3 The plan's *List of Covered Drugs (Formulary)* 6

Section 3.4 The *Explanation of Benefits* (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs 7

SECTION 4 Your monthly premium for SmartD Rx Saver (PDP) 7

Section 4.1 How much is your plan premium? 7

Section 4.2 There are several ways you can pay your plan premium 9

Section 4.3 Can we change your monthly plan premium during the year? 10

SECTION 5 Please keep your plan membership record up to date 10

Section 5.1 How to help make sure that we have accurate information about you 10

SECTION 6 We protect the privacy of your personal health information 11

Section 6.1 We make sure that your health information is protected 11

SECTION 7 How other insurance works with our plan.. 12

Section 7.1 Which plan pays first when you have other insurance?..................................12

SECTION 1 Introduction

Section 1.1 You are enrolled in SmartD Rx Saver (PDP), which is a Medicare Prescription Drug Plan

You are covered by Original Medicare for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, SmartD Rx Saver (PDP).

There are different types of Medicare plans. SmartD Rx Saver (PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, SmartD Rx Saver (PDP), is offered by Smart Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Smart Insurance Company. When it says "plan" or "our plan," it means SmartD Rx Saver (PDP).)

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of SmartD Rx Saver (PDP).

Section 1.3 What does this Chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4 What if you are new to SmartD Rx Saver (PDP)?

If you are a new member, then it's important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how SmartD Rx Saver (PDP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in SmartD Rx Saver (PDP) between January 1, 2013 and December 31, 2013.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve SmartD Rx Saver (PDP) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you have Medicare Part A or Medicare Part B (or you have both Part A and Part B)

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for SmartD Rx Saver (PDP)

Although Medicare is a Federal program, SmartD Rx Saver (PDP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

We offer coverage in all states, the District of Columbia and Puerto Rico. However, there may be cost or other differences between the plans we offer in each state. If you move out of the state or territory where you live into a state or territory that is still within our service area, you must call Member Services in order to update your information.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your membership card for our plan for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network

What are "network pharmacies"?

Our *Pharmacy Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

The *Pharmacy Directory* will also tell you which of the pharmacies in our network are "preferred" network pharmacies. Preferred pharmacies usually have lower cost sharing for covered drugs compared to non-preferred network pharmacies.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.smartdrx.com.

Section 3.3 The plan's List of Covered Drugs (Formulary)

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by SmartD Rx Saver (PDP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the SmartD Rx Saver (PDP) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Members Services to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.smartdrx.com) or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 3.4 The *Explanation of Benefits* (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the "EOB").

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for SmartD Rx Saver (PDP)

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. The monthly premium amount for SmartD Rx Saver (PDP) is listed in Exhibit A on page 124. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, the **information about premiums in this *Evidence of Coverage* may not apply to you**. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of

63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.

- If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 4, Section 10 explains the late enrollment penalty.

- If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B.

Some people pay an extra amount for Part D because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 4, Section 11 of this booklet. You can also visit http://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2013* gives information about the Medicare premiums in the section called "2013 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2013* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium

There are 6 ways you can pay your plan premium. You select your method of premium payment option on your original enrollment form. If you would like to change your premium method, please contact Member Services.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

We will mail you the premium invoice on a monthly basis. All premiums are due on the 1st of the month. If you and your spouse are both enrolled in a Smart Insurance Company plan, your monthly premium must be paid with separate checks. Checks must be made payable to Smart Insurance Company and not to Centers for Medicare & Medicaid Services (CMS) or U.S. Department of Health and Human Services (HHS).

Option 2: You can have payments deducted automatically from your checking or saving account

You can have your premium automatically withdrawn from your checking or saving account via Automatic Bank Withdrawal on a monthly basis. In order to register for the Automatic Bank Withdrawal payment option, please sign, date and return the payment option found on the back of your invoice authorizing this payment option. You can also contact our Member Services to send you an Automatic Bank Withdrawal form to complete. Automatic payments will be withdrawn from your bank account on the first of each month.

Option 3: You can have payment made from automatic recurring credit card payment option

You can have your premium automatically charged to a credit card of your choice on a recurring monthly basis. Contact our Member Services to get more information on how to set up an automatic recurring credit card payment option. Your credit card will be charged monthly on the first of each month.

Option 4: You can make a one-time payment using your credit or debit card

You can make a one-time premium payment of any amount using your credit or debit card. Contact our Member Services to get more information on making a one-time premium payment using your credit or debit card. Premium payment must be made by the 1st of each month. If you and your spouse are both enrolled in Smart Insurance Company plan, you should make separate premium payments using our one-time payment option. We will still continue to mail your premium invoice to you on a monthly basis.

Option 5: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Option 6: You can have the plan premium taken out of your monthly Railroad Retirement Board check

If you qualify for this option, you can have your plan premium taken out of your monthly Railroad Retirement Board check. Contact the Railroad Retirement Board Agency at 1-877-772-5772 or our Member Services for more information. We will be happy to help you to set this up.

What to do if you are having trouble paying your plan premium

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less towards their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the Extra Help program in Chapter 2, Section 7.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

Read over the information we send you about any other insurance coverage you have

That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1 **SmartD Rx Saver (PDP) contacts** (how to contact us, including how to reach Member Services at the plan) **.......... 14**

SECTION 2 **Medicare** (how to get help and information directly from the Federal Medicare program) **.......... 17**

SECTION 3 **State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare) **.......... 19**

SECTION 4 **Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare) **.......... 19**

SECTION 5 **Social Security 20**

SECTION 6 **Medicaid** (a joint Federal and state program that helps with medical costs for some people with limited income and resources) **.......... 21**

SECTION 7 **Information about programs to help people pay for their prescription drugs 21**

SECTION 8 **How to contact the Railroad Retirement Board 24**

SECTION 9 **Do you have "group insurance" or other health insurance from an employer? 24**

SECTION 1 SmartD Rx Saver (PDP) contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to SmartD Rx Saver (PDP) Member Services. We will be happy to help you.

Member Services	
CALL	1-855-976-2781 Calls to this number are free. 24 hours a day, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	1-888-328-0419 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-888-328-0418
WRITE	SmartD Rx Saver (PDP) P.O. Box 1417 Mechanicsburg, PA 17055
WEBSITE	www.smartdrx.com

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

You may call us if you have questions about our coverage decision process.

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Coverage Decisions and Appeals for Part D Prescription Drugs	
CALL	1-855-976-2781Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-888-328-0419 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-888-328-0418
WRITE	SmartD Rx Saver (PDP) ATTN: Appeals & Grievances P.O. Box 1417 Mechanicsburg, PA 17055
WEBSITE	www.smartdrx.com

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Complaints about Part D prescription drugs	
CALL	1-855-976-2781 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-888-328-0419 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-888-328-0418
WRITE	SmartD Rx Saver (PDP) ATTN: Appeals & Grievances P.O. Box 1417 Mechanicsburg, PA 17055
MEDICARE WEBSITE	You can submit a complaint about SmartD Rx Saver (PDP) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of the costs for covered drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Payment Requests	
CALL	1-855-976-2781 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-888-328-0419 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-888-328-0418
WRITE	SmartD Rx Saver (PDP) P.O. Box 1417 Mechanicsburg, PA 17055
WEBSITE	www.smartdrx.com

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

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 (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Prescription Drug Plans, including us.

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about SmartD Rx Saver (PDP): • **Tell Medicare about your complaint:** You can submit a complaint about SmartD Rx Saver (PDP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please reference Exhibit B on page 125 for a complete listing of SHIPs that are available nationally.

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization (QIO) for each state. Please reference Exhibit C on page 131 for a complete listing of QIOs that are available nationally.

QIO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. QIO is an independent organization. It is not connected with our plan.

You should contact QIO if you have a complaint about the quality of care you have received. For example, you can contact QIO if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

Social Security	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am ET to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state-specific Medicaid agency. A complete listing of contact information is provided in Exhibit D on page 141.

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information.)

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

- For assistance you can contact Member Services or if you have the documentation you can mail or fax it to SmartD Rx Saver (PDP), the phone number and contact information are listed on the back of this book.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit http://www.medicare.gov for more information.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount. The plan pays an additional 2.5% and you pay the remaining 47.5% for your brand drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount

provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 21% of the price for generic drugs and you pay the remaining 79% of the price. The coverage for generic drugs works differently than the coverage for brand name drugs. For generic drugs, the amount paid by the plan (21%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. Also, the plan pays 2.5% of the costs of brand drugs in the coverage gap. The 50% discount and the 2.5% paid by the plan are applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn't appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. Please reference Exhibit E on page 151 for a complete listing of State Pharmaceutical Assistance Programs that are available nationally.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	http://www.rrb.gov

SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health or drug benefits, premiums, or enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.)

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Chapter 3. Using the plan's coverage for your Part D prescription drugs

SECTION 1 Introduction 27

Section 1.1 This chapter describes your coverage for Part D drugs 27

Section 1.2 Basic rules for the plan's Part D drug coverage 27

SECTION 2 Fill your prescription at a network pharmacy…………………………..28

Section 2.1 To have your prescription covered, use a network pharmacy 28

Section 2.2 Finding network pharmacies 28

Section 2.3 How can you get a long-term supply of drugs? 29

Section 2.4 When can you use a pharmacy that is not in the plan's network? 30

SECTION 3 Your drugs need to be on the plan's "Drug List"……………………..30

Section 3.1 The "Drug List" tells which Part D drugs are covered 30

Section 3.2 There are 5 "cost-sharing tiers" for drugs on the Drug List 31

Section 3.3 How can you find out if a specific drug is on the Drug List? 32

SECTION 4 There are restrictions on coverage for some drug……………………32

Section 4.1 Why do some drugs have restrictions? 32

Section 4.2 What kinds of restrictions? 32

Section 4.3 Do any of these restrictions apply to your drugs? 33

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?……………………………………………………………………………..34

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered 34

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way? 34

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high? .37

SECTION 6 What if your coverage changes for one of your drugs?....................37

Section 6.1 The Drug List can change during the year...37

Section 6.2 What happens if coverage changes for a drug you are taking?........................38

SECTION 7 What types of drugs are *not* covered by the plan?.............................39

Section 7.1 Types of drugs we do not cover...39

SECTION 8 Show your plan membership card when you fill a prescription 40

Section 8.1 Show your membership card 40

Section 8.2 What if you don't have your membership card with you?..............................40

SECTION 9 Part D drug coverage in special situations 40

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?..40

Section 9.2 What if you're a resident in a long-term care facility? 41

Section 9.3 What if you are taking drugs covered by Original Medicare?........................41

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?..42

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?..42

SECTION 10 Programs on drug safety and managing medications............43

Section 10.1 Programs to help members use drugs safely..43

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), that tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter **explains rules for using your coverage for Part D drugs**. The next chapter tells what you pay for Part D drugs (Chapter 4, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* Handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.4 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Preferred pharmacies are pharmacies in our network where the plan has negotiated lower cost sharing for members for covered drugs than at non-preferred network pharmacies. However, you will usually have lower drug prices at both preferred and non-preferred network pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.smartdrx.com), or call Member Services (phone numbers are printed on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. However, you will usually pay less for your covered drugs if you use a preferred network pharmacy rather than a non-preferred network pharmacy. The *Pharmacy Directory* will tell you which of the pharmacies in our network are preferred network pharmacies.

If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or if the pharmacy you have been using changes from being a preferred network pharmacy to a non-preferred network pharmacy, you may want to switch to a new pharmacy. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.smartdrx.com.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers a way to get a long-term supply of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the lower cost sharing amounts for a long-term supply of maintenance drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of

maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Section 2.4 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- SmartD Rx Saver (PDP) will cover prescriptions filled at out-of-network pharmacies only in the case of an emergency.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.)

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)

- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are 5 "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

Tier 1	Preferred Generic drugs. These drugs provide you with the lowest cost option.
Tier 2	Non-Preferred Generic drugs. These drugs are considered to be non-preferred generic drugs because they have lower cost alternatives.
Tier 3	Preferred Brand drugs. These drugs provide you with the lowest cost brand option.
Tier 4	Non-Preferred Brand drugs. These drugs are considered to be non-preferred brand name drugs because they have lower cost brand name or generic alternatives.
Specialty Tier 5	Specialty Medications. Medications are considered "specialty" due to a high cost, they may be administered via injection, or they may require special handling and storage.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have 3 ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Members Services to find out if we cover it.)
2. Visit the plan's website (www.smartdrx.com). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you OR has written "No substitutions" on your prescription for a brand name drug OR has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy."**

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (www.smartdrx.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of 5 different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.

- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

  We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **For those members who have been in the plan for more than 90 days and their level of care changes:**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year. We will give you an answer to your request for an exception before the change takes effect.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

For drugs in tier 2 and tier 4, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in tier 5.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
    - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
    - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.

- Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7, Section 5.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates, except when used to treat epilepsy, cancer, or a chronic mental health disorder

If you receive Extra Help paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)]

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If

you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. (Chapter 8, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in SmartD Rx Saver (PDP) doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In

addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through SmartD Rx Saver (PDP) in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or SmartD Rx Saver (PDP) for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Chapter 4. What you pay for your Part D prescription drugs

SECTION 1 Introduction 46

Section 1.1 Use this chapter together with other materials that explain your drug coverage 46

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug 47

Section 2.1 What are the drug payment stages for SmartD Rx Saver (PDP) members? 47

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in 48

Section 3.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB") 48

Section 3.2 Help us keep our information about your drug payments up to date 49

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs 50

Section 4.1 You stay in the Deductible Stage until you have paid $325 for your drugs 50

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share 50

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription 50

Section 5.2 A table that shows your costs for a *one-month* supply of a drug 51

Section 5.3 A table that shows your costs for a *long-term* (90-day) supply of a drug 54

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $2,970 56

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 79% of the costs for generic drugs 56

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,750 56

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs 58

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs ... 60

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year ... 60

SECTION 8 Additional benefits information ... 60

Section 8.1 Our plan offers additional benefits ... 60

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them ... 60

Section 9.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot ... 60

Section 9.2 You may want to call us at Member Services before you get a vaccination ... 62

SECTION 10 Do you have to pay the Part D "late enrollment penalty"? ... 62

Section 10.1 What is the Part D "late enrollment penalty"? ... 62

Section 10.2 How much is the Part D late enrollment penalty? ... 63

Section 10.3 In some situations, you can enroll late and not have to pay the penalty ... 63

Section 10.4 What can you do if you disagree about your late enrollment penalty? ... 64

SECTION 11 Do you have to pay an extra Part D amount because of your income? ... 64

Section 11.1 Who pays an extra Part D amount because of income? ... 64

Section 11.2 How much is the extra Part D amount? ... 65

Section 11.3 What can you do if you disagree about paying an extra Part D amount? ... 66

Section 11.4 What happens if you do not pay the extra Part D amount? ... 66

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
    - This Drug List tells which drugs are covered for you.
    - It also tells which of the 5 "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
    - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at www.smartdrx.com. The Drug List on the website is always the most current.

- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for SmartD Rx Saver (PDP) members?

As shown in the table on the next page, there are "drug payment stages" for your prescription drug coverage under SmartD Rx Saver (PDP). How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
You begin in this payment stage when you fill your first prescription of the year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid $325 for your drugs ($325 is the amount of your deductible). (Details are in Section 4 of this chapter.)	During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $2,970. (Details are in Section 5 of this chapter.)	During this stage, you pay 47.5% of the price for brand name drugs plus a portion of the dispensing fee) and 79% of the price for generic drugs. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $4,750. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2013). (Details are in Section 7 of this chapter.)

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back cover of this

booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Section 4.1 You stay in the Deductible Stage until you have paid $325 for your drugs

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is $325 for 2013.

- Your **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid $325 for your drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 5 Cost-Sharing Tiers
Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

Tier 1	Preferred Generic drugs. These drugs provide you with the lowest cost option.
Tier 2	Non-Preferred Generic drugs. These drugs are considered to be non-preferred generic drugs because they have lower cost alternatives.
Tier 3	Preferred Brand drugs. These drugs are brand name drug options which provide the lowest net cost. The lowest net cost takes into

	consideration other medications and/or medical oversight that may be required which adds to the overall cost of therapy.
Tier 4	Non-Preferred Brand Name drugs. These drugs are considered to be non-preferred brand name drugs because they have lower cost brand name or generic alternatives.
Specialty Tier 5	Specialty Medications. Medications are considered "specialty" due to a high cost, they may be administered via injection, or they may require special handling and storage.

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A preferred retail pharmacy that is in our plan's network
- A non-preferred network retail pharmacy
- A pharmacy that is not in the plan's network

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and the plan's *Pharmacy Directory.*

Preferred pharmacies are pharmacies in our network where members have lower cost sharing for covered drugs than at non-preferred network pharmacies. However, you will usually have lower drug prices at both preferred and non-preferred network pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.4 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply (or less) of a covered Part D prescription drug from:

	Preferred Network pharmacy (up to a 30-day supply)	**Non-Preferred Network pharmacy** (up to a 30-day supply)	**Network long-term care pharmacy** (up to a 91-day supply)	**Out-of-network pharmacy** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generics)	$0.00	$10.00	$10.00	$10.00
Cost-Sharing Tier 2 (Non-Preferred Generics)	Please reference Table A on the next page	$33.00*With the exception of Alaska which is $20.00 for a 30-day supply	$33.00	$33.00
Cost-Sharing Tier 3 (Preferred Brands)	Please reference Table A on the next page	$45.00 *With the exception of Alaska which is $35.00 for a 30-day supply	$45.00	$45.00
Cost-Sharing Tier 4 (Non-Preferred Brands)	Please reference Table A on the next page	$95.00 *With the exception of Alaska which is $65.00 for a 30-day supply	$95.00	$95.00
Cost-Sharing Tier 5 (Specialty)	25%	25%	25%	25%

Table A
30-Day Copay Amounts for Tiers 2, 3 & 4
From a Preferred Network Pharmacy

To use the table below, find the state where you live. The copay amounts listed are for a 30-day supply and are based on the tier your medication falls into on the formulary.

Tier 2 – Non-Preferred Generics
Tier 3 – Preferred Brands
Tier 4 – Non-Preferred Brands

State	Tier 2	Tier 3	Tier 4
Alabama	$20.00	$34.00	$85.00
Alaska	$10.00	$25.00	$55.00
Arizona	$20.00	$32.00	$79.00
Arkansas	$20.00	$30.00	$77.00
California	$20.00	$32.00	$85.00
Colorado	$20.00	$31.00	$85.00
Connecticut	$20.00	$35.00	$85.00
Delaware	$20.00	$35.00	$81.00
Dist. of Columbia	$20.00	$35.00	$81.00
Florida	$24.00	$35.00	$85.00
Georgia	$20.00	$35.00	$80.00
Hawaii	$21.00	$30.00	$85.00
Idaho	$21.00	$30.00	$85.00
Illinois	$20.00	$33.00	$85.00
Indiana	$20.00	$32.00	$85.00
Iowa	$15.00	$30.00	$80.00
Kansas	$16.00	$30.00	$80.00
Kentucky	$20.00	$32.00	$85.00
Louisiana	$20.00	$30.00	$77.00
Maine	$10.00	$25.00	$62.00
Maryland	$20.00	$35.00	$81.00
Massachusetts	$20.00	$35.00	$85.00
Michigan	$20.00	$33.00	$85.00
Minnesota	$15.00	$30.00	$80.00
Mississippi	$20.00	$30.00	$85.00
Missouri	$20.00	$32.00	$85.00

State	Tier 2	Tier 3	Tier 4
Montana	$15.00	$30.00	$80.00
Nebraska	$15.00	$30.00	$80.00
Nevada	$20.00	$33.00	$85.00
New Hampshire	$10.00	$25.00	$62.00
New Jersey	$20.00	$35.00	$81.00
New Mexico	$20.00	$32.00	$81.00
New York	$20.00	$35.00	$85.00
North Carolina	$21.00	$35.00	$85.00
North Dakota	$15.00	$30.00	$80.00
Ohio	$20.00	$32.00	$85.00
Oklahoma	$20.00	$35.00	$85.00
Oregon	$17.00	$30.00	$80.00
Pennsylvania	$20.00	$31.00	$85.00
Puerto Rico	$20.00	$35.00	$82.00
Rhode Island	$20.00	$35.00	$85.00
South Carolina	$20.00	$33.00	$81.00
South Dakota	$15.00	$30.00	$80.00
Tennessee	$20.00	$34.00	$85.00
Texas	$20.00	$34.00	$84.00
Utah	$21.00	$30.00	$85.00
Vermont	$20.00	$35.00	$85.00
Virginia	$20.00	$31.00	$84.00
Washington	$17.00	$30.00	$80.00
West Virginia	$20.00	$31.00	$85.00
Wisconsin	$20.00	$34.00	$85.00
Wyoming	$15.00	$30.00	$80.00

Section 5.3 A table that shows your costs for a *long-term* (90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3.)

The table below shows what you pay when you get a long-term (90-day) supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:

	Preferred Network pharmacy (90-day supply)	**Non-Preferred Network Pharmacy** (90-day supply)
Cost-Sharing Tier 1 (Preferred Generics)	$0.00	$25.00
Cost-Sharing Tier 2 (Non-Preferred Generics)	Please reference Table B on the next page	$82.50 *With the exception of Alaska which is $50.00 for a 90-day supply
Cost-Sharing Tier 3 (Preferred Brands)	Please reference Table B on the next page	$112.50 *With the exception of Alaska which is $87.50 for a 90-day supply
Cost-Sharing Tier 4 (Non-Preferred Brands)	Please reference Table B on the next page	$237.50 *With the exception of Alaska which is $162.50 for a 90-day supply
Cost-Sharing Tier 5 (Specialty Medications)	25%	25%

Table B

90-Day Copay Amounts for Tiers 2, 3 & 4 From a Preferred Network Pharmacy

To use the table below, find the state where you live. The copay amounts listed are for a 90-day supply and are based on the tier your medication falls into on the formulary.

Tier 2 – Non-Preferred Generics
Tier 3 – Preferred Brands
Tier 4 – Non-Preferred Brands

State	Tier 2	Tier 3	Tier 4
Alabama	$50.00	$85.00	$212.50
Alaska	$25.00	$62.50	$137.50
Arizona	$50.00	$80.00	$197.50
Arkansas	$50.00	$75.00	$192.50
California	$50.00	$80.00	$212.50
Colorado	$50.00	$77.50	$212.50
Connecticut	$50.00	$87.50	$212.50
Delaware	$50.00	$87.50	$202.50
Dist. of Columbia	$50.00	$87.50	$202.50
Florida	$60.00	$87.50	$212.50
Georgia	$50.00	$87.50	$200.00
Hawaii	$52.50	$75.00	$212.50
Idaho	$52.50	$75.00	$212.50
Illinois	$50.00	$82.50	$212.50
Indiana	$50.00	$80.00	$212.50
Iowa	$37.50	$75.00	$200.00
Kansas	$40.00	$75.00	$200.00
Kentucky	$50.00	$80.00	$212.50
Louisiana	$50.00	$75.00	$192.50
Maine	$25.00	$62.50	$155.00
Maryland	$50.00	$87.50	$202.50
Massachusetts	$50.00	$87.50	$212.50
Michigan	$50.00	$82.50	$212.50
Minnesota	$37.50	$75.00	$200.00
Mississippi	$50.00	$75.00	$212.50
Missouri	$50.00	$80.00	$212.50
Montana	$37.50	$75.00	$200.00
Nebraska	$37.50	$75.00	$200.00
Nevada	$50.00	$82.50	$212.50
New Hampshire	$25.00	$62.50	$155.00
New Jersey	$50.00	$87.50	$202.50
New Mexico	$50.00	$80.00	$202.50
New York	$50.00	$87.50	$212.50
North Carolina	$52.50	$87.50	$212.50
North Dakota	$37.50	$75.00	$200.00
Ohio	$50.00	$80.00	$212.50
Oklahoma	$50.00	$87.50	$212.50
Oregon	$42.50	$75.00	$200.00
Pennsylvania	$50.00	$77.50	$212.50
Puerto Rico	$50.00	$87.50	$205.00
Rhode Island	$50.00	$87.50	$212.50
South Carolina	$50.00	$82.50	$202.50
South Dakota	$37.50	$75.00	$200.00
Tennessee	$50.00	$85.00	$212.50
Texas	$50.00	$85.00	$210.00
Utah	$52.50	$75.00	$212.50
Vermont	$50.00	$87.50	$212.50
Virginia	$50.00	$77.50	$210.00
Washington	$42.50	$75.00	$200.00
West Virginia	$50.00	$77.50	$212.50
Wisconsin	$50.00	$85.00	$212.50
Wyoming	$37.50	$75.00	$200.00

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $2,970

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$2,970 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The $325 you paid when you were in the Deductible Stage.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2013, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the $2,970 limit in a year.

We will let you know if you reach this $2,970 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 79% of the costs for generic drugs

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,750

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 47.5% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 79% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (21%)

does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 79% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2013, that amount is $4,750.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $4,750, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

*These payments **are included** in your out-of-pocket costs*

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage.
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $4,750 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are <u>not</u> included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **<u>not</u> allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you**. The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $4,750 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $4,750 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - *–either* – coinsurance of 5% of the cost of the drug
  - *–or* – $2.65 copayment for a generic drug or a drug that is treated like a generic. Or a $6.60 copayment for all other drugs.
- **Our plan pays the rest** of the cost.

SECTION 8 Additional benefits information

Section 8.1 Our plan offers additional benefits

There are no additional benefits under this plan.

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
    - Other vaccines are considered medical benefits. They are covered under Original Medicare.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible and Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine and administration of the vaccine.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet (*Asking us to pay our share of the costs for covered drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Section 9.2 You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination. (Phone numbers for Member Services are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 10 Do you have to pay the Part D "late enrollment penalty"?

Section 10.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how

many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The penalty is added to your monthly premium. When you first enroll in SmartD Rx Saver (PDP), we let you know the amount of the penalty.

Your late enrollment penalty is considered part of your plan premium

Section 10.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2013, this average premium amount is $31.17.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $31.17, which equals $4.36. This rounds to $4.40. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

There are three important things to note about this monthly late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 10.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
    - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
    - For additional information about creditable coverage, please look in your *Medicare & You* 2013 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 10.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

SECTION 11 Do you have to pay an extra Part D amount because of your income?

Section 11.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or

married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

Section 11.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2011 was:	If you were married but filed a separate tax return and your income in 2011 was:	If you filed a joint tax return and your income in 2011 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$11.60
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$29.90
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$48.30
Greater than $214,000	Greater than $129,000	Greater than $428,000	$66.60

Section 11.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 11.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

Chapter 5. Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs 68

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment 68

SECTION 2 How to ask us to pay you back.. 69

Section 2.1 How and where to send us your request for payment.....................................69

SECTION 3 We will consider your request for payment and say yes or no 70

Section 3.1 We check to see whether we should cover the drug and how much we owe ..70

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal 70

SECTION 4 Other situations in which you should save your receipts and send copies to us 71

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs 71

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, 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. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Sec. 2.4 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the plan to get your member information, but there may be times when you may need to pay if you do not have your card.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.smartdrx.com) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Mail your request for payment together with any receipts to us at this address:

SmartD Rx Saver (PDP)
Attn: DMR
P.O. Box 1417
Mechanicsburg, PA 17055

You must submit your claim to us within 3 years of the date you received the service, item, or drug.

Contact Member Services if you have any questions. If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The examples of situations in which you may need to ask our plan to pay you back:

- When you use an out-of-network pharmacy to get a prescription filled
- When you pay the full cost for a prescription because you don't have your plan membership card with you
- When you pay the full cost for a prescription in other situations

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an

introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage and Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible Stage and Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these

drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan 74

Section 1.1 We must provide information in a way that works for you (in languages other than English, Braille, or other alternate formats, etc.) 74

Section 1.2 We must treat you with fairness and respect at all times......................................74

Section 1.3 We must ensure that you get timely access to your covered drugs 75

Section 1.4 We must protect the privacy of your personal health information 75

Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs 76

Section 1.6 We must support your right to make decisions about your care...........................77

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made 78

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected? 78

Section 1.9 How to get more information about your rights 79

SECTION 2 You have some responsibilities as a member of the plan 80

Section 2.1 What are your responsibilities?...80

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Spanish, Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Para obtener información en un formato que le resulte útil, llame a Servicios para Miembros (los números de teléfono se encuentran en la parte de atrás de este manual).

Nuestro plan cuenta con personas y servicios de traducción gratuitos para responder las preguntas de las personas que no hablan inglés. También podemos ofrecerle la información en Braille, en letra grande u otro formato alternativo si usted lo necesita. Si usted es elegible para tener Medicare por una discapacidad, estamos obligados a brindarle información accesible y adecuada acerca de los beneficios del plan.

Si tiene problemas para obtener información de nuestro plan por razón de idioma o discapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana, y comuníqueles que desea presentar una queja. Los usuarios de TTY deben llamar al 1-877-486-2048.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 We must ensure that you get timely access to your covered drugs

As a member of our plan, you also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee 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 work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of SmartD Rx Saver (PDP), you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
  - For more detailed information about our pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at www.smartdrx.com.
- **Information about your coverage and rules you must follow in using your coverage.**
  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
  - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your State Department of Health)]. Please reference Exhibit F on page 159 for a complete listing of State Health Departments.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- ***Get familiar with your covered drugs and the rules you must follow to get these covered drugs.*** *Use this* Evidence of Coverage *booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.*
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- ***If you have any other prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).*
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your plan membership card whenever you get your Part D prescription drugs.*
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance

(a percentage of the total cost) Chapter 4 tells what you must pay for your Part D prescription drugs.

- If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).*
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- ***Call Member Services for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
  - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction 84

Section 1.1 What to do if you have a problem or concern 84

Section 1.2 What about the legal terms? 84

SECTION 2 You can get help from government organizations that are not connected with us 85

Section 2.1 Where to get more information and personalized assistance 85

SECTION 3 To deal with your problem, which process should you use? 86

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints? 86

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals 87

Section 4.1 Asking for coverage decisions and making appeals: the big picture 87

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal 88

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal 89

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug 89

Section 5.2 What is an exception? 90

Section 5.3 Important things to know about asking for exceptions 92

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception 92

Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)....95

Section 5.6 Step-by-step: How to make a Level 2 Appeal 97

SECTION 6 Taking your appeal to Level 3 and beyond.... 99

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals....99

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns.... 102

Section 7.1 What kinds of problems are handled by the complaint process?....102

Section 7.2 The formal name for "making a complaint" is "filing a grievance"....104

Section 7.3 Step-by-step: Making a complaint....105

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization....106

Section 7.5 You can also tell Medicare about your complaint....106

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected to us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. Please reference Exhibit B on page 125 for a complete listing of SHIPs that are available nationally. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and making appeals."**	Skip ahead to **Section 7** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- For Part D prescription drugs, your doctor or other prescriber can request a coverage determination or a Level 1 or 2 appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 3 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 4 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 5.2** of this chapter.	You can ask us for a coverage decision. Skip ahead to **Section 5.4** of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 5.4** of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in tier 4 for brand name drugs or tier 2 for generic drugs or tier 5 for specialty drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 3).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of *5* cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If your drug is in tier 2 you can ask us to cover it at the cost-sharing amount that applies to drugs in tier 1. This would lower your share of the cost for the drug.
- If your drug is in tier 4 you can ask us to cover it at the cost-sharing amount that applies to drugs in tier 3. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in tier 5.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the

section called, *Where to send a request that asks us to pay for our share of the cost for a drug you have received.*

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 5 of this booklet: *Asking us to pay our share of the costs for covered drugs.* Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.

If your health requires it, ask us to give you a "fast coverage decision"

Legal Terms	A "fast coverage decision" is called an **"expedited coverage determination."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

Step 2: We consider your request and we give you our answer.

*Deadlines for a **"fast"** coverage decision*

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision about a drug you have not yet received*

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**

  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision about payment for a drug you have already bought*

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start your appeal, you, your doctor, or your representative, must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs.*

- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact our plan when you are making an appeal about your part D prescription drugs).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms	A "fast appeal" is also called an **"expedited redetermination."**

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.4 of this chapter.

<u>Step 2:</u> We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

*Deadlines for a **"fast" appeal***

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we tell about this

review organization and explain what happens at Level 2 of the appeals process.)

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a ***"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
    - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

*Deadlines for **"fast" appeal** at Level 2*

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

*Deadlines for **"standard" appeal** at Level 2*

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.

- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Have you been kept waiting too long by pharmacists? Or by our Member Services or other staff at the plan?
  - Examples include waiting too long on the phone or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a pharmacy?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints
(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms	
	• What this section calls a **"complaint"** is also called a **"grievance."** • Another term for **"making a complaint"** is **"filing a grievance."** • Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-855-976-2781, TTY: 1-888-328-0419, 24 hours a day, 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- When describing your complaint, make sure to include as much detail as you have, (e.g. dates, names, etc.), this will assist in our investigation of your complaint. Most importantly, let us know about your complaint as soon as possible. You must submit your complaint to us within 60 calendar days after the problem occurred. If you have a complaint regarding our decision not to provide an expedited appeal or grievance we will give you a response to your complaint within 24 hours. You can access a form online at www.smartdrx.com or send a written explanation to us at: SmartD Rx Saver (PDP), ATTN: Appeals & Grievances, P.O. Box 1417, Mechanicsburg, PA 17055 or via fax to 1-888-328-0419.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint**. If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about SmartD Rx Saver (PDP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction ... 108

Section 1.1 This chapter focuses on ending your membership in our plan ... 108

SECTION 2 When can you end your membership in our plan? ... 108

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period 108

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period ... 109

Section 2.3 Where can you get more information about when you can end your membership? ... 111

SECTION 3 How do you end your membership in our plan? ... 111

Section 3.1 Usually, you end your membership by enrolling in another plan ... 111

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan ... 113

Section 4.1 Until your membership ends, you are still a member of our plan ... 113

SECTION 5 SmartD Rx Saver (PDP) must end your membership in the plan in certain situations ... 114

Section 5.1 When must we end your membership in the plan? ... 114

Section 5.2 We cannot ask you to leave our plan for any reason related to your health ... 115

Section 5.3 You have the right to make a complaint if we end your membership in our plan ... 115

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in SmartD Rx Saver (PDP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
    - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
    - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare prescription drug plan.

- Original Medicare *without* a separate Medicare prescription drug plan.
  - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
  - If you enroll in most Medicare health plans, you will be disenrolled from SmartD Rx Saver (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep SmartD Rx Saver (PDP) for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of SmartD Rx Saver (PDP) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
  - If you have moved out of your plan's service area.
  - If you have Medicaid.
  - If you are eligible for Extra Help with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care hospital.

  - PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are printed on the back cover of this booklet).

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare health plans, you will automatically be disenrolled from SmartD Rx Saver (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep SmartD Rx Saver (PDP) for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2013*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, there are two situations in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep SmartD Rx Saver (PDP) for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or ask to be disenrolled from our plan.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- *--or--*You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 4, Section 10 for more information about the late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	**This is what you should do:**
• Another Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from SmartD Rx Saver (PDP) when your new plan's coverage begins.
• A Medicare health plan.	• Enroll in the Medicare health plan. With most Medicare health plans, you will automatically be disenrolled from SmartD Rx Saver (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep SmartD Rx Saver (PDP) for your drug coverage. If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact Member Services (phone numbers are printed on the back cover of this booklet) if you need more information

If you would like to switch from our plan to:	This is what you should do:
	on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).
• Original Medicare *without* a separate Medicare prescription drug plan. o **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 4, Section 10 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave SmartD Rx Saver (PDP), it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy.

SECTION 5 SmartD Rx Saver (PDP) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

SmartD Rx Saver (PDP) must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law ... 117

SECTION 2 Notice about nondiscrimination ... 117

SECTION 3 Notice about Medicare Secondary Payer subrogation rights ... 117

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, SmartD Rx Saver (PDP), as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

Chapter 10. Definitions of important words

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,750 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible – The amount you must pay for prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

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

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage after you have met your deductible and before your total drug expenses have reached $2,970, including amounts you've paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare*,* a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and

Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

Out-of-Pocket Costs – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Part C – see "Medicare Advantage (MA) Plan."

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

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our plan at lower cost-sharing levels than apply at a non-preferred network pharmacy.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

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

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security 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.

SmartD Rx Saver (PDP) Exhibit A

Premium Table

Use the table below to identify the monthly premium amount for your state.

State	Region	Monthly Premium Amount
Alabama	12	$33.20
Alaska	34	$34.10
Arizona	28	$29.20
Arkansas	19	$32.40
California	32	$31.40
Colorado	27	$33.20
Connecticut	02	$32.40
Delaware	05	$34.60
Dist. of Columbia	05	$34.60
Florida	11	$30.40
Georgia	10	$32.40
Hawaii	33	$32.80
Idaho	31	$41.70
Illinois	17	$29.60
Indiana	15	$35.70
Iowa	25	$35.70
Kansas	24	$36.00
Kentucky	15	$35.70
Louisiana	21	$36.30
Maine	01	$32.70
Maryland	05	$34.60
Massachusetts	02	$32.40
Michigan	13	$34.70
Minnesota	25	$35.70
Mississippi	20	$33.20
Missouri	18	$33.20

State	Region	Monthly Premium Amount
Montana	25	$35.70
Nebraska	25	$35.70
Nevada	29	$35.40
New Hampshire	01	$32.70
New Jersey	04	$35.50
New Mexico	26	$29.40
New York	03	$40.70
North Carolina	08	$32.20
North Dakota	25	$35.70
Ohio	14	$30.20
Oklahoma	23	$32.20
Oregon	30	$37.30
Pennsylvania	06	$35.10
Puerto Rico	38	$14.50
Rhode Island	02	$32.40
South Carolina	09	$36.80
South Dakota	25	$35.70
Tennessee	12	$33.20
Texas	22	$31.50
Utah	31	$41.70
Vermont	02	$32.40
Virginia	07	$31.00
Washington	30	$37.30
West Virginia	06	$35.10
Wisconsin	16	$37.30
Wyoming	25	$35.70

SmartD Rx Saver (PDP) Exhibit B

State Health Insurance Assistance Program (SHIP)

Note that if you find a broken link or incorrect phone number; please notify SmartD Rx so we can correct the information.

Alabama
State Health Insurance Assistance Program (SHIP)
Website: www.adss.alabama.gov/ship.cfm
Phone: (800) 243-5463

Alaska
State Health Insurance Assistance Program (SHIP) & Senior Medicare Patrol (SMP)
Website: www.hss.state.ak.us/dsds/medicare
Toll-free in Alaska: (800) 478-6065 Anchorage: (907) 269-3680, TTY: (800) 770-8973

Arizona
State Health Insurance Assistance Program (SHIP)
Website: www.azdes.gov/daas/ship
Statewide Hotline: (800) 432-4040 (leave message)

Arkansas
Senior Health Insurance Information Program (SHIIP)
Website: www.insurance.arkansas.gov/seniors/divpage.htm
Phone: (800) 224-6330, (501) 371-2782

California
California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)
Website: www.aging.ca.gov/hicap/default.aspx
Phone: (800) 434-0222

Colorado
Senior Health Insurance Assistance Program (SHIP)
Website: www.dora.state.co.us/insurance/senior/senior.htm
Phone: (888) 696-7213, En Espanol, sin cargo (866) 665-9668

Connecticut
The CHOICES Program
Website: www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313032
Phone: (800) 994-9422

Delaware

ELDERinfo

Website: www.delawareinsurance.gov/departments/elder/eldindex.shtml

Phone: (800) 336-9500, (302) 674-7364

Florida

SHINE (Serving Health Insurance Needs of Elders)

Website: www.floridashine.org

Phone: (800) 963-5337, TTY/TDD: (800) 955-8770

Georgia

GeorgiaCares

Website: www.mygeorgiacares.org/Home/SHIP/tabid/62/Default.aspx

Phone: (800) 669-8387

Hawaii

Sage PLUS Program

Website: www.hawaiiship.org

Phone: (808) 586-7299 or (888) 875-9229

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)

Website: www.doi.idaho.gov/shiba/shwelcome.aspx

Phone: (800) 247-4422

Illinois

Senior Health Insurance Program (SHIP)

Website: www.insurance.illinois.gov/ship

Phone: (800) 548-9034

Indiana

Senior Health Insurance Program (SHIP)

Website: www.in.gov/idoi/2500.htm

Phone: (800) 452-4800

Iowa

Senior Health Insurance Information Program (SHIIP)

Website: www.shiip.state.ia.us/FindACounselor.aspx

Phone: (800) 351-4664, TTY: (800) 735-2942

Kansas

Senior Health Insurance Counseling For Kansas (SHICK)

Website: www.kdads.ks.gov /SHICK/shick_index.html

Phone: (800) 860-5260

Kentucky

Kentucky State Health Insurance Assistance Program (SHIP)
Website: www.chfs.ky.gov/dail/ship.htm
Phone: (877) 293-7447

Louisiana

Senior Health Insurance Information Program (SHIIP)
Website: www.ldi.louisiana.gov/Health/SHIIP/index.html
Phone: (800) 259-5300, (225) 219-7731

Maine

State Health Insurance Assistance Program (SHIP)
Website: www.maine.gov/dhhs/oes/resource/health_insurance.htm
Phone: (877) 353-3771, TTY: (800) 750-5353, Local/Out of State: (207) 623-1797

Maryland

Senior Health Insurance Assistance Program (SHIP)
Website: www.aging.maryland.gov/senior.html
Phone: (800) 243-3425 – ext 71108

Massachusetts

The SHINE Program (Serving Health Information Needs of Elders)
Website: www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html
Phone: (800) 243-4636, press 3

Michigan

Medicare/Medicaid Assistance Program (MMAP)
Website: http://mmapinc.org/pages/about.html
Phone: (800) 803-7174

Minnesota

Minnesota State Health Insurance Assistance Program (SHIP)
Website: www.mnaging.org/advisor/SLL_SHIP.htm
Phone: (800) 333-2433

Mississippi

State Health Insurance Assistance Program (SHIP)
Website: www.mdhs.state.ms.us/aas_ship.html
Phone: (800) 948-3090, (601) 359-4929

Missouri

Community Leaders Assisting the Insured of Missouri (CLAIM)
Website: www.missouriclaim.org
Phone: (800) 390-3330

Montana
Montana State Health Insurance Assistance Program (SHIP)
Website: www.dphhs.mt.gov/sltc/services/aging/SHIP/ship.shtml
Phone: (800) 551-3191

Nebraska
The Nebraska Senior Health Insurance Information Program (SHIIP)
Website: www.doi.ne.gov/shiip
Phone: (800) 234-7119, (402) 471-2201, TTY: (800) 833-7352

Nevada
State Health Insurance Assistance Program (SHIP)
Website: www.nvaging.net/ship/ship_main.htm
Phone: (800) 307-4444, Las Vegas: (702) 486-3478

New Hampshire
ServiceLink Resource Centers
Website: www.nh.gov/servicelink/medicareinfo.html
Phone: (866) 634-9412

New Jersey
State Health Insurance Assistance Program (SHIP)
Website: www.state.nj.us/health/senior/ship.shtml
Phone: (800) 792-8820

New Mexico
State Health Insurance Assistance Program (SHIP)
Website: www.nmaging.state.nm.us/State_Health_Insurance_Assistance_Program.aspx
Phone: (800) 432-2080, Toll-free in New Mexico: (505) 476-4846

New York
Health Insurance Information, Counseling and Assistance (HIICAP)
Website: www.aging.ny.gov/healthbenefits/HIICAPIndex.cfm
Phone: (800) 701-0501

North Carolina
Seniors' Health Insurance Information Program (SHIIP)
Website: www.ncdoi.com/SHIIP/Default.aspx
Phone: (800) 443-9354, (919) 807-6900

North Dakota
Senior Health Insurance Counseling (SHIC) Program
Website: www.nd.gov/ndins/consumer/shic
Phone: (800) 575-6611, (701) 328-2440, TTY: (800) 366-6888

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)
Website: www.insurance.ohio.gov/aboutodi/odidiv/pages/oshiip.aspx
Phone: (800) 686-1578, (614) 644-3458

Oklahoma

Senior Health Insurance Counseling Program (SHIP)
Website: www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html
Phone: (800) 763-2828

Oregon

Senior Health Insurance Benefits Assistance (SHIBA)
Website: www.oregon.gov/DCBS/SHIBA
Phone: (800) 722-4134 Message Line

Pennsylvania

Apprise Health Insurance Counseling Program
Website: www.portal.state.pa.us/portal/server.pt?open=514&objID=616587&mode=2
Phone: (800) 783-7067

Puerto Rico

Puerto Rico State Health Insurance Assistance Program
Phone: (877) 725-4300

Rhode Island

Rhode Island Senior Health Insurance Program (SHIP)
Website: www.dea.ri.gov/insurance/
Phone: (401) 462-3000, TTY: (401) 462-0740

South Carolina

Insurance Counseling Assistance and Referrals for Elders program (I-CARE)
Website: www.aging.sc.gov/seniors/medicare/Pages/index.aspx
Phone: (800) 868-9095 (General Office of Aging line)

South Dakota

Senior Health Information & Insurance Education (SHIINE)
Website: www.shiine.net
Phone: SHIINE Eastern South Dakota: (800) 536-8197 or (605) 333-3314
Central South Dakota: (877) 331-4834 or (605) 224-3212
Western South Dakota: (877) 286-9072 or (605) 342-8635

Tennessee

The Tennessee State Health Insurance Assistance Program (SHIP)
Website: www.tn.gov/comaging/ship.html
Phone: (877) 801-0044

Texas
Health Information Counseling & Advocacy Program of Texas (HICAP)
Website: www.tdi.texas.gov/consumer/hicap/hicaphme.html
Phone: (800) 252-3439

Utah
Medicare/Medigap/Med Advantage
Website: www.hsdaas.utah.gov/hiip_contact_list.htm
Phone: (800) 541-7735

Vermont
The Vermont State Health Insurance Assistance Program (SHIP)
Website: www.medicarehelpvt.net
Phone: (800) 642-5119

Virginia
Virginia Insurance Counseling and Assistance Program (VICAP)
Website: www.vda.virginia.gov/vicap2.asp
Phone: (800) 552-3402, Richmond/Henrico local: (804) 662-9333

Washington
Statewide Health Insurance Benefits Advisors (SHIBA)
Website: www.insurance.wa.gov/shiba/index.shtml
Phone: (800) 562-6900

Washington D.C.
Health Insurance Counseling Project (HICP)
Website: www.law.gwu.edu/Academics/EL/clinics/insurance/Pages/About.aspx
Phone: (202) 739-0668, TTY: (202) 973-1079

West Virginia
State Health Insurance Assistance Programs (SHIP)
Website: www.wvship.org/AboutWVSHIP/tabid/132/Default.aspx
Phone: (877) 987-4463, (304) 558-3317

Wisconsin
The Medigap Helpline
Website: www.dhs.wisconsin.gov/aging/BOALTC/MEDIGAP.HTM
Phone: (800) 242-1060

Wyoming
Wyoming State Health Insurance Information Program (WSHIIP)
Website: www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program
Phone: (800) 856-4398

SmartD Rx Saver (PDP) Exhibit C

Quality Improvement Organizations (QIO)

Listed by State

Note that if you find a broken link or incorrect phone number; please notify SmartD Rx so we can correct the information.

Alabama

AQAF
Two Perimeter Park South
Suite 200 West
Birmingham, AL 35243
Phone: (205) 970-1600
Fax: (205) 970-1616
Website: http://www.aqaf.com/

Alaska

Mountain Pacific Quality Health
4241 B Street, Suite 303
Anchorage, AK 99503
Phone: (907) 561-3202 or (877) 561-3202
Fax: (907) 561-3204
Website: http://www.mpqhf.org/

Arizona

Health Services Advisory Group
3133 East Camelback Road, Suite 300
Phoenix, AZ 85016-4501
Phone: (602) 264-6382
Fax: (602) 241-0757
Website: http://www.hsag.com/home.aspx

Arkansas

Arkansas Foundation for Medical Care
124 W. Capitol Avenue, Suite 990b
Little Rock, AR 72201-3704
Phone: (877) 375-5700
Website: http://www.afmc.org/

California

Health Services Advisory Group
Subsidiary of Health Services Holdings (HSH)
700 N. Brand Blvd., Suite 370
Glendale, CA 91203
Phone: (818) 409-9229
Fax: (818) 409-0835
Website: http://www.hsag.com/home.aspx

Colorado

Colorado Foundation for Medical Care
23 Inverness Way East, Suite 100
Englewood, CO 80112-5708
Phone: (303) 755-1912
Fax: (303) 695-3300
Website: http://www.hsag.com/home.aspx

Connecticut

Qualidigm
1111 Cromwell Avenue, Suite 201
Rocky Hill, CT 06067-3454
Phone: (860) 632-2008
Fax: (860) 632-5865
Website: http://www.qualidigm.org/

Delaware

Quality Insights of Delaware
Baynard Building, Suite 100
3411 Silverside Road
Wilmington, DE 19810-4812
Phone: (302) 478-3600 or (866)475-9669
Fax: (302) 478-4109 (Administration)
Fax: (302) 478-3873 (Beneficiary and Family Centered Care)
Website: http://www.qide.org/Home.aspx

Florida

FMQAI: (Subsidiary of Health Services Holdings (HSH):
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Phone: (813) 354-9111
Website: http://www.fmqai.com/

Georgia

Alliant Georgia Medical Care Foundation GMFC
1455 Lincoln Parkway, Suite 800
Atlanta, GA 30346
Phone: (678) 527-3000
Website: http://www.gmcf.org/

Hawaii

Mountain Pacific Quality Health
1360 S. Beretania, Suite 501
Honolulu, HI 96814
Phone: (808) 545-2550 or (800) 524-6550
Fax: (808) 440-6030
Website: http://www.mpqhf.org/

Idaho

Qualis Health
720 Park Blvd., #120
Boise, ID 83712
Phone: (208) 343-4617 or (800) 488-1118
Fax: (208) 343-4705
Website: http://www.qualishealthmedicare.org/

Illinois

IFMC - IL
711 Jorie Blvd, Suite #301
Oak Brook, Illinois 60523-4425
Phone: (630) 928-5800 or (800) 386-6431
Website: http://www.ifmc-il.org/

Indiana

Health Care Excel, Incorporated Corporate Office
2629 Waterfront Parkway East Drive, Suite 150
Indianapolis, IN 46214
Phone: (317) 347-4500
Fax: (317) 347-4567
Website: http://www.hce.org/contact-us

Iowa

Telligen
1776 West Lakes Parkway
West Des Moines, IA 50266
Phone: (515) 223-2900 or (800) 383-2856
Website: http://www.internetifmc.com/contact.html

Kansas

Kansas Foundation for Medical Care, Inc.
2947 SW Wanamaker Drive
Topeka, KS 66614-4193
Phone : (785) 273-2552 or (800) 432-0770
Website: http://www.kfmc.org/

Kentucky

Health Care Excel of Kentucky, Incorporated
1941 Bishop Lane, Suite 400
Louisville, KY 40218
Phone: (502) 454-5112
Fax: (502) 454-5113
Website: http://www.hce.org/contact-us

Louisiana

eQHealth Solutions Offices
8591 United Plaza Boulevard, Suite 270
Baton Rouge, Louisiana 70809
Phone: (225) 926-6353
Fax: (225) 923-0957
Website: http://louisianaqio.eqhs.org/

Maine

Northeast Quality Health Foundation
15 Old Rollinsford Rd., Suite 302
Dover, NH 03820
Phone: (603)749-1641 or (800) 772-0151
Fax: (603)749-1195
Website: http://www.nhcqf.org

Maryland

Delmarva Foundation for Medical Care, Inc.
6940 Columbia Gateway Drive, Suite 420
Columbia, MD 21046
Phone: (410) 285-0190 or (800) 876-3362
Website: http://www.mdqio.org

Massachusetts

Mass Pro
245 Winter St.
Waltham MA, 02451
Phone: (781) 890-0011, TTY: (877) 486-2048
Fax: (781) 487-0083
Website: http://www.masspro.org/contacts.php

Michigan
MPRO
22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335
Phone: (248) 465-7300
Fax: (248) 465-7420
Website: http://www.mpro.org/

Minnesota
Stratis Health
2901 Metro Drive, Suite 400
Bloomington, MN 55425-1525
Phone: (952) 854-3306 or (877) STRATIS (877-787-2847)
Fax: (952) 853-8503
Email: www.stratishealth.org

Mississippi
Information and Quality Healthcare
385B Highland Colony Parkway, Suite 504
Ridgeland MS 39157
Phone: (601) 957-1575
Fax: (601) 956-1713
Website: http://www.iqh.org/

Missouri
Primaris
200 N. Keene Street, Suite 101
Columbia, Missouri 65201
Phone: (573) 817-8300 or (800) 735-6776, TTY: (800) 735-2966
Website: http://www.primaris.org/

Montana
Mountain Pacific Quality Health
3404 Cooney Dr.
Helena, MT 59602
Phone: (406) 443-4020 or (800) 497-8232
Fax: (406) 513-1920
Website: http://www.mpqhf.org/

Nebraska
CIMBRO of Nebraska
1230 O Street, Suite 120
Lincoln, Nebraska 68508
Phone: (402) 476-1399 or (800) 458-4262
Website: http://www.cimronebraska.org/default.aspx

Nevada

Health Insight
6830 West Oquendo Road, Suite 102
Las Vegas, Nevada 89118
Phone: (702) 385-9933
Fax: (702) 385-4586
Website: http://www.healthinsight.org

New Hampshire

Northeast Health Care Quality Foundation
15 Old Rollinsford Rd., Suite 302
Dover, NH 03820
Phone: (603)749-1641 or (800) 772-0151
Fax: (603)749-1195
Website: http://www.nhcqf.org

New Jersey

Healthcare Quality Strategies, Inc.
557 Cranbury Road, Suite 21
East Brunswick, NJ 08816
Phone: (800) 624-4557
Website: http://www.hqsi.org/

New Mexico

Health Insight
5801 Osuna Road NE, Suite 200
Albuquerque, New Mexico 87109
Phone: (505) 998-9898 or (800) 663-6351
Fax: (505) 998-9899
Website: http://www.nmmra.org/

New York

IPRO
1979 Marcus Avenue
Lake Success, NY 11042-1002
Phone: (516) 326-7767, TTY: (516) 326-6182
Fax: (516) 328-2310
Website: http://www.ipro.org/

North Carolina

The Carolinas Center for Medical Excellence
100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598
Phone: (919) 461-5500 or (800) 682-2650, TTY: 800-735-2962
Fax: (919) 461-5700
Website: http://www.ccmemedicare.org/

North Dakota

North Dakota Health Care Review, Inc. NDHCRI
3520 North Broadway
Minot, ND 58703
Phone: (701) 852-4231 (Minot Area), 800-472-4231 (Inside ND), (888) 472-4231 (Outside ND)
Fax: (701) 857-9755 (Main), 701-838-6009 (Review Only)
Website: http://www.ndhcri.org/

Ohio

Ohio KePRO
Ohio KePRO Rock Run Center, Suite 100
5700 Lombardo Center Dr.
Seven Hills, OH 44131
Phone: (216) 447-9604
Fax: (216) 447-7925
Website: http://www.ohiokepro.com/

Oklahoma

Oklahoma Foundation for Medical Quality
14000 Quail Springs Parkway, Suite 400
Oklahoma City, OK 73134-2600
Phone: (405) 840-2891
Administrative Fax: (405) 840-1343 (use for all communication except confidential personal health information)
HIPAA Secure Fax: (405) 858-9097 (use for all confidential personal health information)
Website: http://www.ofmq.com/

Oregon

Acumentra Health
2020 SW Fourth Avenue, Suite 520
Portland, OR 97201
Phone: (503)279-0100
Fax: (503) 279-0190
Website: http://www.acumentra.org/

Pennsylvania

Quality Insights
Quality Insights of Pennsylvania
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
Phone: (877) 346-6180 or (717) 671-5425
Website: http://www.qipa.org/

Puerto Rico
Quality Improvement Professional Research Organization, Inc.
Phone: (877) 566-0566
Website: http://www.qipro.org/

Rhode Island
Healthcentric Advisors
235 Promenade Street, Suite 500, Box 18
Providence, RI 02908
Phone: (401) 528-3200
Website: http://www.healthcentricadvisors.org/

South Carolina
The Carolinas Center for Medical Excellence
246 Stoneridge Drive, Suite 200
Columbia, SC 29210
Phone: (800) 922-3089 or (803) 212-7500 (local), TTY: (800) 735-8583
Fax: (803)212-7600
Website: http://www.ccmemedicare.org/

South Dakota
South Dakota Foundation for Medical Care
2600 West 49th Street, Suite 300
Sioux Falls, SD 57105
Phone: (605) 336-3505 or (800) MEDICARE
Fax: (605) 373-0580
Website: http://www.sdfmc.org

Tennessee
QSource
3340 Players Club Pkwy
Memphis, TN 38125
Phone: (800) 528-2655
Fax: (901) 761-3786
Website: http://www.qsource.org/

Texas
TMF Health Quality Institute
Bridgepoint I, Suite 300
5918 West Courtyard Drive
Austin, TX 78730-5036
Phone: (512) 329-6610 or (800) 725-9216
Fax: (512) 327-7159
Website: http://www.tmf.org/

Utah

Health Insight
756 East Winchester Street, Suite 200
Salt Lake City, Utah 84107
Phone: (801) 892-0155
Fax: (801) 892-0160
Website: http://www.healthinsight.org

Vermont

Northeast Quality Health Foundation
15 Old Rollinsford Rd., Suite 302
Dover, NH 03820
Phone: (603)749-1641 or (800) 772-0151
Fax: (603)749-1195
Website: http://www.nhcqf.org

Virginia

VHQC
9830 Mayland Drive, Suite J
Richmond, VA 23233
Phone: (804) 289-5320
Website: http://www.vhqc.org/

Washington

Qualis Healthcare
PO Box 33400
Seattle, WA 98133-0400
Phone: (206) 364-9700 or (800) 949-7536
Fax: (206) 368-2419
Website: http://www.qualishealthmedicare.org

Washington D.C.

Delmarva Foundation for Medical Care, Inc.
2175 K Street NW, Suite 250
Washington, DC 20037
Phone: (800) 937-3362
Fax: (201) 293-9650
Website: http://www.dcqio.org/

West Virginia

WVMI Quality Insights
3001 Chesterfield Ave.
Charleston, WV 25311
Phone: (800) 642-8686
Website: http://www.qiwv.org/

Wisconsin

MetaStar, Inc.
2909 Landmark Place
Madison, WI 53713
Phone: (608) 274-1940 or (800) 362-2320
Fax: (608) 274-5008
Website: http://www.metastar.com/web/

Wyoming

Mountain Pacific Quality Health
145 S. Durbin, Suite 105
Casper, WY 82601
Phone: (307) 472-0507 (local), (877) 810-6248 (toll free)
Fax: (307) 472-1791
Website: http://www.mpqhf.org/

SmartD Rx Saver (PDP) Exhibit D

Medicaid Agencies

Listed by State

Note that if you find a broken link or incorrect phone number; please notify SmartD Rx so we can correct the information.

Alabama

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36104
Phone: (334) 242-5000 or (800) 362-1504
Website: http://www.medicaid.alabama.gov/

Alaska

Senior Benefits Office
855 W. Commercial Drive
Wasilla, AK 99654
Phone: (352) 4150 or (888) 352-4150
Fax: (357) 2561 or (866) 352-8539
Website: http://www.hss.state.ak.us/

Arizona

Medicaid AHCCCS
801 E. Jefferson Street, MD 4100
Phoenix, AZ 85034
Phone: (602) 417-4000 or (800) 654-8713
Fax: (602) 252-6536
Website: http://www.azahcccs.gov/

Arkansas

Arkansas Division of Medical Services
Department of Human Services
Donaghey Plaza South
P. O. Box 1437, Slot S401
Little Rock, Arkansas 72203-1437
Phone: (800) 482-5431
Website: https://www.medicaid.state.ar.us/

California

Medi-Cal California Medicaid Services
Phone: (916) 445-4171
MCI from TDD: (800) 735-2929 MCI from voice telephone: (800) 735-2922
Contact: Sprint from TDD (800) 877-5378 Sprint from voice telephone (800) 877-5379
Website: http://www.dhcs.ca.gov/Pages/default.aspx

Colorado

Colorado Medicaid Services
P.O. Box 1100
Denver, CO 80201
Phone: (800) 237-0757
Website: http://www.colorado.gov/hcpf

Connecticut

HUSKY Health Program/Charter Oak Health Plan
P. O. Box 280747
East Hartford, CT 06108
Phone: (800) 859-9889
Website: http://www.huskyhealth.com/hh/site/default.asp

Delaware

Department of Medicaid Services –Delaware
Main Administration Building, First Floor Annex
1901 N. DuPont Highway
New Castle, DE 19720
Phone: (302) 255-9390 or (800) 223-9074
Fax: (302) 255-4454
Website: http://dhss.delaware.gov/dhss/dmma/medicaid.html

Florida

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
Phone: (888) 367-6554
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml

Georgia

Department of Community Health-Medicaid Services Main Office
2 Peachtree Street, NW
Atlanta, GA 30303
Phone: (404) 656-4507
Website: http://dch.georgia.gov/

Hawaii

Administrative offices –Medicaid Services
1250 Punchbowl St.
Honolulu, Hawaii 96813
Phone: (808) 586-4400
Fax: (808) 586-4444
Website: http://hawaii.gov/health/

Idaho

Idaho Department of Health and Welfare-Medicaid Services
PO Box 83720
Boise, ID 83720-0036
Phone: (877) 456-1233 or call the Idaho CareLine at 2-1-1
Regional offices found at:
Website: http://www.healthandwelfare.idaho.gov/ContactUs/tabid/127/Default.aspx

Illinois

Department on Aging – Medicaid Assistance
401 South Clinton Street
Chicago, Illinois 60607
Phone: (800) 43-6154, TTY: (800) 447-6404
Fax: (217) 785-4477
Website: http://www.hfs.illinois.gov/medical/apply.html

Indiana

Member Services- Medicaid
Hoosier Healthwise
P.O. Box 3127
Indianapolis, IN 46206-312
Phone: (317) 713-9627 or (800) 457-4584
Opt 1 = Member Services - English
Opt 2 = Member Services – Spanish
Website: http://member.indianamedicaid.com/

Iowa

Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315
Phone: (515) 256-4600 or (800) 338-8366
Website: http://www.dhs.iowa.gov/

Kansas

Department of Health & Human Services- Centers for Medicare and Medicaid Services
601 East 12th Street, Suite 235
Kansas City, MO 64104
Phone: (785) 296-4986 or (800) 432-3535, TTY Number: (785) 291-3167
Fax: (785) 296-0256
Website: http://www.kdheks.gov/hcf/healthwave/default.htm

Kentucky

Department for Medicaid Services
Cabinet for Health and Family Services
Office of the Secretary
275 E. Main St.
Frankfort, KY 40621
Phone: (800) 635-2570
Local Office Search: https://apps.chfs.ky.gov/Office_Phone/index.aspx

Louisiana

Louisiana Medicaid
628 N. 4th Street
Baton Rouge, LA 70802
Phone: (225) 342-9500 or (888) 342-6207
Fax: (225) 342-5568

Maine

Office of Elder Services-Medicaid
Maine Department of Health and Human Services
11 State House Station
32 Blossom Lane Augusta, Maine 04333
Phone: (207) 287-9200 or (800) 262-2232, TTY: Maine relay 711
Fax: (207) 287-9229
Website: http://www.maine.gov/dhhs/oes/index.shtml

Maryland

Medicaid Services- Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201
Phone: (410) 767-5800 or (800) 492-5231
Website:
http://mmcp.dhmh.maryland.gov/SitePages/Medicaid%20Eligibility%20and%20Benefits.aspx

Massachusetts

MassHealth Member & Applicant
One Ashburton Place,11th Floor
Boston, MA 02108
MassHealth Member Customer Service Center
Phone: (800) 841-2900, TTY: (800) 497-4648
Website: http://www.mass.gov/eohhs/consumer/insurance/masshealth-apply/65-plus/senior-care-options.html

Michigan

Michigan Department of Community Health -Medicaid
Capitol View Building
201 Townsend Street
Lansing, Michigan 48913
Phone: (517) 373-3740
Website: http://michigan.gov/mdch/

Minnesota

Medicaid Services
MinnesotaCare
PO Box 64838
St. Paul, MN 55164-0838

Walk-in office
540 Cedar Street
St. Paul, MN
Phone: (651) 297-3862 or (800) 657-3672, TTY: (800) 627-3529 or 711
Website: http://www.dhs.state.mn.us/

Mississippi

Regional Offices listing
Phone: (800) 421-2408
Website: http://www.medicaid.ms.gov/RegionalOffices.aspx

Missouri

Broadway State Office Building- Medicaid Services
P.O. Box 1527
Jefferson City, MO 65102-1527
Telephone: (573) 751-4815
Text Telephone: (800) 735-2966
TDD Voice Access: (800) 735-2466
Fax: (573) 751-3203
Website: http://dss.mo.gov/ddo/

Montana

Medicaid and Health Services
111 North Sanders, Room 301, Helena, MT 59620
PO Box 4210, Helena, MT 59604-4210
Phone: (406) 444-5622
Fax: (406) 444-1970
Website: http://www.dphhs.mt.gov/

Nebraska
DHHS Division of Public Health – Medicaid Services
1033 O Street, Suite 500
Lincoln, NE 68508
Phone: (877) 255-3092 or (800) 642-6092 (Nebraska Medicaid Eligibility System)
Website: http://dhhs.ne.gov/medicaid/

Nevada
Aging Services – Medicaid Services
3416 Goni Rd., Bldg D, Suite 132
Carson City, Nevada 89706
Phone: (775) 687-4210 or (775) 684-3600
Website: http://dhcfp.state.nv.us/MSPTableofContents.htm

New Hampshire
Office of Medicaid
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301
Phone: (603) 271-4344 or (800) 852-3345, ext. 4344, TDD: (800) 735-2964
Website: http://www.dhhs.state.nh.us/ombp/medicaid/index.htm

New Jersey
NJ Department of Human Services
Division of Medical Assistance and Health Services
PO Box 712
Trenton, NJ 08625-0712
Phone: 1-800-356-1561
Website: http://www.state.nj.us/humanservices/dmahs/home/index.html

New Mexico
NM Human Services Department's Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348
Phone: (505) 827-3100 (local Santa Fe) or (888) 997-2583
Fax: (505) 827-3185
Website: http://www.hsd.state.nm.us/

New York
Medicaid Services- New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237
Phone: (800) 541-2831
Website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_transition/

North Carolina

NC Division of Medical Assistance- Medicaid Offices
2501 Mail Service Center
Raleigh, NC 27699-2501
Phone: (800) 662-7030 (English, Spanish)
Website: http://www.ncdhhs.gov/dma/medicaid/apply.htm

North Dakota

North Dakota Department of Health- Medicaid Offices
600 East Boulevard Avenue
Bismark, ND 58505-0200
Phone: (701) 328-2436 or (800) 755-2714
Fax: (701) 328-1645
Website: http://www.ndhealth.gov/familyhealth/

Ohio

Department of Family Services - Medicaid
30 E. Broad Street, 32nd Floor
Columbus, Ohio 43215
Phone: (800) 324-8680, TTY/TDD: (800) 292-3572
Website: http://jfs.ohio.gov/OHP/index.stm

Oklahoma

Oklahoma Healthcare Authority –Medicaid Services
2401 N.W. 23rd St., Suite 1A
Oklahoma City, OK 73107
Phone: (800) 987-7767, TDD: (800) 757-5979
Website: http://www.okhca.org/

Oregon

Medicaid Division- Department of Human Services
500 Summer St. NE
Salem 97301
Phone: (503) 945-5944 or (800) 527-5772, TTY: (503) 945-6214 or (800) 375-2863
Fax: (503) 378-2897
Website: http://www.oregon.gov/dhs/healthplan/pages/app_benefits/main.aspx

Pennsylvania

County Offices for Medicaid Services listing
Department of Public Welfare
P.O. Box 2675, Harrisburg, PA 17105-2675
Phone: (800) 692-7462
Website: http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/index.htm

Puerto Rico
PO Box 7018
San Juan, PR 00936
Phone: (787) 765-1230
Website: http://www.salud.gov.pr/Pages/default.aspx

Rhode Island
PACE Organization of Rhode Island
225 Chapman Street
Providence, RI 02905
Phone: (401) 490-6566
Toll-free: (877) 781-PACE (877-781-7223)
Fax: (401) 490-6537
Website: http://www.pace-ri.org/AboutPACE/OverviewHistory/tabid/155/Default.aspx

South Carolina
South Carolina Health and Human Services- Medicaid Division
P.O. Box 8206
Columbia, SC 29202
Phone: (888) 549-0820
Website: http://www.scdhhs.gov/service/how-apply

South Dakota
Social Services of South Dakota- Medicaid Services
700 Governors Drive
Pierre, SD 57501
Phone: (605) 773-4678
Fax: (605) 773-7183
Email: MedElig@state.sd.us
Website: http://dss.sd.gov/medicalservices/

Tennessee
TennCare – Medicaid services program
310 Great Circle Rd
Nashville, TN 37243
Phone: (800) 342-3145
Website: http://www.tn.gov/tenncare/members.shtml

Texas
Medicaid Services- Texas Health and Human Services Commission
Brown-Heatly Building
4900 N. Lamar Blvd.
Austin, TX 78751-2316
Phone: (800) 252-8263
Website: https://www.yourtexasbenefits.com/ssp/SSPHome/ssphome.jsp

Utah

Utah Department of Health- Division of Medicaid and Health Financing
P.O. Box 143106
Salt Lake City, UT 84114-3106
Phone: (800) 662-9651
Website: http://www.health.utah.gov/medicaid/index.html

Vermont

Economic Services Division-Medicaid
103 South Main Street
Waterbury, VT 05676-1500
Phone: (800) 479-6151
Website: http://dcf.vermont.gov/mybenefits

Virginia

Department of Medical Assistance Services
Attn: Medicaid Office
600 East Broad Street
Richmond, VA 23219
Phone: (804) 786-7933, TDD: (800) 343-0634
Website: DMAS-Info@dmas.virginia.gov

Washington

Medicaid DSHS Customer Service Center
P.O. Box 11699
Tacoma, WA 98411-9905
Phone: (800) 562-3022
http://hrsa.dshs.wa.gov/medicaidsp/

Washington D.C.

Department of Health –Medicaid Services
899 North Capitol Street, NE, Suite 6037
Washington, DC 20002
Phone: (202) 442-5988
Website: http://www.dchealth.dc.gov/doh/site/default.asp

West Virginia

Bureau of Senior Services-Medicaid Office
1900 Kanawha Blvd. East, Charleston, WV 25305
Town Center Mall, 3rd level, Charleston, WV
Phone: (304) 558-3317 or (877) 987-3646
Fax: (304) 558-5609
Website: http://www.dhhr.wv.gov/bms/Pages/default.aspx

Wisconsin

Department of Health Services
1 West Wilson Street
Madison, WI 53703
Phone: (800) 362-3002 (toll free)
Website: http://www.dhs.wisconsin.gov/forwardhealth/

Wyoming

Division of Healthcare
6101 Yellowstone Road, Suite 210
Cheyenne, WY 82002
Phone: (307) 777-7531
Fax: (307) 777-6964
Website: https://healthlink.wyo.gov/

SmartD Rx Saver (PDP) Exhibit E

State Pharmaceutical Assistance Program (SPAP)

Listed by State

Note that if you find a broken link or incorrect phone number; please notify SmartD Rx so we can correct the information.

Colorado

Colorado Bridging the Gap
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246
Phone: (303) 692-2783 or (303) 692-2716
Website: http://www.cdphe.state.co.us/dc/HIVandSTD/ryanwhite/insurance.html

Connecticut

Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE)
P.O. BOX 5011
Hartford, CT 06102
Phone: (800) 423-5026 or (860) 269-2029
Website: http://connpace.com/

Delaware

Delaware Prescription Assistance Program (PDAP)
P.O. Box 950
New Castle, DE 19720
Phone: (800) 996-9969 EXT: 2
Website: http://www.dhss.delaware.gov/dhss/dmma/dpap.html

Delaware Chronic Renal Disease Program
11-13 North Church Ave
Milford, DE 19963
Phone: (302) 424-7180 or (800) 464-4357
Website: http://www.dhss.delaware.gov/dhss/dmma/crdprog.html

Idaho

Idaho AIDS Drug Assistance Program (IDAGAP)
Department of Health and Welfare
P. O. Box 83720
Boise, ID 83720
Phone: (208) 334-5943 or (800) 926-2588
Website:
http://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx

Illinois

Illinois Cares Rx Plus
Illinois Department on Aging
P.O. Box 19003
Springfield, IL 62794
Phone: (800) 226-0768
Website: http://www.illinoiscaresrx.com/

Illinois Cares Rx Basic
Illinois Department on Aging
P.O. Box 19003
Springfield, IL 62794
Phone: (800) 624-2459 or (800) 252-8966
Website: http://www.illinoiscaresrx.com/

Indiana

HoosierRx
P.O. Box 6224
Indianapolis, IN 46206
Phone: (866) 267-4679 or (317) 234-1381
Website: http://www.in.gov/fssa/elderly/hoosierrx/

Maine

Maine Low Cost Drugs for the Elderly or Disabled Program
Office of MaineCare Services
442 Civic Center Drive
Augusta, ME 04333
Phone: (866) 796-2463
Website: http://www.maine.gov/dhhs/beas/resource/lc_drugs.htm

Maryland

Maryland Senior Prescription Drug Assistance Program
Maryland SPDAP
c/o Pool Administrators
628 Hebron Avenue, Suite 212
Glastonbury, CT 06033
Phone: (800) 551-5995
Website: http://marylandspdap.com

Maryland Kidney Disease Program
201 West Preston Street - Room SS-3
Baltimore, MD 21201
Phone: (410) 767-5000 or (800) 226-2142
Website: http://www.mdrxprograms.com/kdp.html

Primary Adult Care Program (PAC)
Primary Adult Care Program
P.O. Box 386
Baltimore, MD 21203
Phone: (800) 226-2142
Website: http://mmcp.dhmh.maryland.gov/mpac/SitePages/Home.aspx

Massachusetts

Massachusetts Prescription Advantage
P. O. Box 15153
Worcester, MA 01615
Phone: (800) 243-4636 EXT: 2
Website: http://mmcp.dhmh.maryland.gov/mpac/SitePages/Home.aspx

Missouri

Missouri Rx Plan
P. O. Box 6500
Jefferson City, MO 65102
Phone: (800) 375-1406
Website: http://morx.mo.gov/

Montana

Montana Big Sky Rx Program
P.O. Box 202915
Helena, MT 59620
Phone: (866) 369-1233 or (406) 444-1233
Website: http://www.dphhs.mt.gov/prescriptiondrug/bigsky.shtml

Montana Mental Health Services Plan (MHSP)
555 Fuller Avenue
P.O. Box 202905
Helena, MT 59620
Phone: (406) 444-3964 or (800) 866-0328
Website: http://www.dphhs.mt.gov/amdd/services/mhsp.shtml

Bridging the Gap
P. O. Box 202951
Cogswell Building C-211
Helena, MT 59620
Phone: (406) 444-4744

Nevada

Nevada Senior Rx Program
Nevada Senior Rx- Department of Health and Human Services
3416 Goni Road, Suite B-113
Carson City, NV 89706
Phone: (866) 303-6323 or (775) 687-4210
Website: http://dhhs.nv.gov/SeniorRx.htm

Nevada Disability Rx
Department of Health and Human Services
3416 Goni Road, Suite B-113
Carson City, NV 89706
Phone: (866) 303-6323 or (775) 687-4210
Website: http://dhhs.nv.gov/DisabilityRx.htm

New Jersey

New Jersey Senior Gold Prescription Discount Program
Senior Gold Prescription Discount Program
P.O. Box 715
Trenton, NJ 08625
Phone: (800) 792-9745
Website: http://www.state.nj.us/health/seniorbenefits/seniorgold.shtml

New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)
PAAD-HAAAD
P.O. Box 715
Trenton, NJ 08625
Phone: (800) 792-9745
Website: http://www.state.nj.us/health/seniorbenefits/paad.shtml

New Jersey Division of Medical Assistance and Health Services
NJ Department of Human Services- Division of Medical Assistance and Health Services
P. O. Box 712
Trenton, NJ 08625
Phone: (800) 356-1561
Website: http://www.state.nj.us/humanservices/dmahs/index.html

New York

New York State Elderly Pharmaceutical Insurance Coverage (EPIC)
EPIC
P.O. Box 15018
Albany, NY 12212
Phone: (800) 332-3742
Website: http://www.health.state.ny.us/nysdoh/epic/faq.htm

North Carolina

North Carolina HIV SPAP
1902 Mail Service Center
Raleigh, NC 27699
Phone: (877) 466-2232 or (919) 733-7301
Website: http://epi.publichealth.nc.gov/cd/hiv/adap.html

Pennsylvania

Pharmaceutical Assistance Contract for the Elderly (PACE)
PACE Program
1st Health Services
4000 Crums Mill Road, Suite 301
Harrisburg, PA 17112
Phone: (800) 225-7223 or (717) 651-3600
Website: http://www.aging.state.pa.us/portal/server.pt/community/pace___pacenet/17944

Pennsylvania PACE Needs Enhancement Tier (PACENET)
PACENET Program
P.O. Box 8806
Harrisburg, PA 17105
Phone: (800) 225-7223 or (717) 651-3600
Website: https://pacecares.magellanhealth.com/

Special Pharmaceutical Benefits Program - HIV/AIDS
Department of Public Welfare
Special Pharmaceutical Benefits Program
P.O. Box 8021
Harrisburg, PA 17105
Phone: (800) 922-9384
Website:
http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/aidswaiverprogram/specialpharmaceuticalbenefitsprogram/index.htm

Special Pharmaceutical Benefits Program - Mental Health
OMHSAS - Business Part Support Unit
SPBP-2 112 East Azalea Drive
Harrisburg, PA 17110
Phone: (800) 433-4459 or (877) 356-5355
Website:
http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/aidswaiverprogram/specialpharmaceuticalbenefitsprogram/index.htm

Rhode Island

Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)
Attention RIPAE
Rhode Island Department of Elderly Affairs
Hazard Building, Second Floor
74 West Road
Cranston, RI 02920
Phone: (401) 462-3000 or (401) 462-0740
Website: http://www.dea.state.ri.us/RIPAE/index.php

Texas

Texas Kidney Health Care Program (KHC)
Kidney Health Care Program
Department of State Health Services, MC 1938
P.O. Box 149347
Austin, TX 78714
Phone: (800) 222-3986 or (512) 776-7150
Website: http://www.dshs.state.tx.us/kidney/default.shtm

Texas HIV State Pharmacy Assistance Program (SPAP)
ATTN: MSJA-MC 1873
P.O. Box 149347
Austin, TX 78714
Phone: (800) 255-1090 EXT: 3004
Website: http://www.dshs.state.tx.us/hivstd/meds/spap.shtm

Vermont

VPharm
312 Hurricane Lane, Suite 201
Williston, VT 05495
Phone: (800) 250-8427
Website: http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance

Vermont VSCRIPT Expanded
312 Hurricane Lane, Suite 201
Williston, VT 05495
Phone: (802) 879-5900 or (800) 250-8427
Website: http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance

Vermont Health Access Plan (VHAP-Pharmacy)
312 Hurricane Lane, Suite 201
Williston, VT 05495
Phone: (802) 879-5900 or (800) 250-8427
Website: http://ovha.vermont.gov/for-consumers

Vermont VPHARM
312 Hurricane Lane, Suite 201
Williston, VT 05495
Phone: (802) 879-5900 or (800) 250-8427
Website: http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance

Virginia

Virginia HIV SPAP
P. O. Box 5930
Midlothin, VA 23112
Phone: (800) 366-7741
Website: http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/spap.htm

Washington

Washington State Health Insurance Pool
P.O. Box 1090
Great Bend, KS 67530
Phone: (800) 877-5187
Website: https://www.wship.org/Default.asp

Wisconsin

Wisconsin SeniorCare
P.O. Box 6710
Madison, WI 53716
Phone: (800) 657-2038
Website: http://www.dhs.wisconsin.gov/seniorcare/

Wisconsin Chronic Renal Disease
Chronic Disease Program ATTN: Eligibility Unit
P. O. Box 6410
Madison, WI 53716
Phone: (800) 947-9627 or (800) 362-3002
Website:
https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage

Wisconsin Cystic Fibrosis Program
Wisconsin Chronic Disease Program
P. O. Box 6410
Madison, WI 53716
Phone: (800) 947-9627 or (800) 362-3002
Website:
https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage

Wisconsin Hemophilia Home Care
Wisconsin Chronic Disease Program
P. O. Box 6410
Madison, WI 53716
Phone: (800) 947-9627 or (800) 362-3002
Website:
https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage

SmartD Rx Saver (PDP) Exhibit F

State Health Departments

Note that if you find a broken link or incorrect phone number; please notify SmartD Rx so we can correct the information.

Alabama
The RSA Tower
201 Monroe Street
Montgomery, Alabama 36104
Phone: (334) 206-5300 or (800) ALA-1818
Website: http://www.adph.org

Alaska
350 Main Street, Room 404
PO Box 110601
Juneau, Alaska 99811-0601
Phone: (907) 465-3030
Fax: (907) 465-3068
Website: http://www.hss.state.ak.us

Arizona
150 North 18th Avenue
Phoenix, Arizona 85007
Phone: (602) 542-1025
Fax: (602) 542-0883
Website: http://www.azdhs.gov/

Arkansas
Arkansas Department of Health
4815 West Markham Street
Little Rock, Arkansas 72205
Phone: (501) 661-2000 or (800) 462-0599
Website: http://www.healthy.arkansas.gov/

California
California Department of Health
P.O. Box 997413, MS 8500
Sacramento, CA 95899-7413
Phone: (916) 449-5770
Website: http://www.dhcs.ca.gov/

Colorado

Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530
Website: http://www.cdphe.state.co.us/about.html

Connecticut

Connecticut Department of Health
410 Capitol Avenue,
P.O. Box 340308,
Hartford, Connecticut 06134-0308
Phone: (860) 509-8000, TTY: (860) 509-7191
Website: http://www.ct.gov/dph/

Delaware

Department of Public Health
417 Federal Street
Jesse Cooper Building
Dover, DE 19901
Phone: (302) 744-4700
Fax: (302) 739-6659
Website: http://dhss.delaware.gov/dhss/main/contacts.htm

Florida

Florida Department of Health
2585 Merchants Row Boulevard
Tallahassee, FL
Phone: (850) 245-4444
Website: http://www.doh.state.fl.us/

Georgia

Department of Public Health
Two Peachtree Street, NW
Atlanta, Georgia 30303-3186
Phone: (404) 657-2700
Website: http://www.health.state.ga.us/contact.asp

Hawaii

Hawaii Department of Health
1250 Punchbowl Street
Honolulu, HI 96813
Phone: (808) 586-4400
Website: http://hawaii.gov/health

Idaho

Idaho Department of Health and Welfare
PO Box 83720
Boise, ID 83720-0036
Phone: (8770 456-1233
Website: http://www.healthandwelfare.idaho.gov/

Illinois

Illinois Department of Health and Welfare
535 W. Jefferson St.
Springfield, IL 62761
Phone: (217) 782-4977
Website: http://www.idph.state.il.us/

Indiana

Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204
Phone: (317) 233-1325
Website: http://www.state.in.us/isdh/18934.htm

Iowa

Iowa Department of Health
321 E. 12th Street
Des Moines, Iowa, 50319-0075
Phone: (515) 281-7689 or (866) 227-9878
Website: http://www.idph.state.ia.us/contact_us.asp

Kansas

Kansas Department of Health
1000 SW Jackson Ste 540
Topeka, Kansas 66612
Phone: (785) 296-0461
Website: http://www.kdheks.gov/health/

Kentucky

Department for Public Health
275 East Main Street
Frankfort, KY 40621
Phone: (502) 564-3970
Website: http://chfs.ky.gov/dph/info/

Louisiana

Department of Health and Hospitals
628 N. 4th Street
Baton Rouge, LA 70802
Phone: (225) 342-9500
Fax: (225) 342-5568
Website: http://new.dhh.louisiana.gov/index.cfm/page/3/n/3

Maine

Department of Health and Human
221 State Street
Augusta, Maine 04333-0040
Phone: (207) 287-3707, TTY: Maine relay 711
Fax: (207) 287-3005
Website: http://www.maine.gov/dhhs/

Maryland

Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201
Phone: (410) 767-6500 or (877) 4MD-DHMH (877-463-3464)
Website: http://dhmh.maryland.gov/

Massachusetts

Department of Health and Human Service
One Ashburton Place
11th Floor
Boston, MA 02108
Phone: (617) 573-1600
Website: http://www.mass.gov/eohhs/utility/contact-us.html#ehs

Michigan

Michigan Department of Health
Capitol View Building
201 Townsend Street
Lansing, Michigan 48913
Phone: (517) 373-3740
Website: http://www.michigan.gov/mdch/

Minnesota

Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975
Phone: (651) 201-5000 or (888) 345-0823 - For Minnesota callers outside the metro area
TTY: (651) 201-5797
Website: http://www.health.state.mn.us/about/direct.html

Mississippi

Mississippi State Department of Health
570 East Woodrow Wilson Drive
Jackson, MS 39216
Phone: (866) 458-4948 (866-HLTHY4U)
Website: http://msdh.ms.gov/msdhsite

Missouri

Missouri Department of Health and Senior Services
912 Wildwood
P.O. Box 570
Jefferson City, Missouri 65102
Phone: (573) 751-6400
Fax: (573) 751-6010
Website: http://health.mo.gov/

Montana

Montana Department of Public Health
111 North Sanders, Room 301, Helena, MT 59620
PO Box 4210, Helena MT 59604-4210
Phone: (406) 444-5622
Fax: (406) 444-1970
Website: http://www.dphhs.mt.gov/directorsoffice/index.shtml

Nebraska

Nebraska Department of Health and Human Services
301 Centennial Mall South,
Lincoln, Nebraska 68509-5026
Phone: (402) 471-6035 or (800) 254-4202
Website: http://dhhs.ne.gov/Pages/contact.aspx

Nevada

Nevada State Health Division
4150 Technology Way
Carson City, NV 89706-2009
Phone: (775) 684-4200
Fax: (775) 684-4211
Website: http://www.health.nv.gov/ContactUs.htm

New Hampshire

New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3852
Phone: (603) 271-9200
Website: http://www.dhhs.state.nh.us/

New Jersey

New Jersey Department of Health
P. O. Box 360,
Trenton, NJ 08625-0360
Phone: (800) 328-3838
Website: http://www.state.nj.us/health/

New Mexico

New Mexico Department of Health
1190 South St. Francis Drive
Santa Fe, NM 87502
Phone: (505) 827-2613
Fax: (505) 827-2530
http://nmhealth.org

New York

New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237
Phone: (866) 881-2809
Website: http://www.health.ny.gov/

North Carolina

Department of Health and Human Services
Adams Building
101 Blair Dr.
Raleigh, NC 27699-2001
Phone: (919) 855-4800
Website: http://www.ncdhhs.gov/contacts/index.htm

North Dakota

North Dakota Department of Health
600 East Boulevard Avenue
Bismarck, N.D. 58505-0200
Phone: (701) 328-2372
Fax: (701) 328-4727
Website: http://www.ndhealth.gov/

Ohio

Ohio Department of Health
246 N. High St.
Columbus, Ohio 43215
Phone: (614) 466-3543
Website: http://www.odh.ohio.gov/

Oklahoma

Oklahoma State Department of Health
1000 NE 10th
Oklahoma City, OK 73117
Phone: (405) 271-5600, or (800) 522-0203 (available 8 a.m. to 5 p.m. CST).
Website: http://www.ok.gov/health/Contact_OSDH.html

Oregon

Oregon Public Health
800 NE Oregon Street, Suite 930
Portland, OR 97232
Phone: (971) 673-1222, TTY: (971) 673-0372
Fax: (971) 673-1299
Website: http://public.health.oregon.gov/

Pennsylvania

Pennsylvania Department of Health
Health and Welfare Building
8th Floor West
625 Forster Street
Harrisburg, PA 17120
Phone: (877) PA-HEALTH (877-724-3258)
Website: http://www.portal.state.pa.us/

Puerto Rico

Puerto Rico Department of Health
PO Box 70184
San Juan, PR 00936-8184
Phone: (787) 274-7874 or (787) 274-7875
Fax: (787) 274-5739

Rhode Island

Rhode Island Department of Health
3 Capitol Hill
Providence RI 02908
Phone: (401) 222-5960
Website: http://www.health.ri.gov/contactus/

South Carolina

South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201
Phone: (803) 898-DHEC ((803) 898-3432)
Website: http://www.scdhec.gov/

South Dakota

South Dakota Health Department
600 East Capital Ave
Pierre SD, 57501
Phone: (800) 738-2801
Website: http://doh.sd.gov/

Tennessee

Tennessee Department of Health
425 5th Avenue North
Cordell Hull Building, 3rd Floor
Nashville, Tennessee 37243
Phone: (615) 741-3111
Website: http://health.state.tn.us/contact.htm

Texas

Texas Department of State Health Services
1100 West 49th Street
Austin, TX 78756
Phone: (512) 776-7111
Website: http://www.dshs.state.tx.us/

Utah

Utah Department of Health
Cannon Health Building
288 North 1460 West
Salt Lake City, UT 84116
Phone: (801) 538-6003
Website: http://health.utah.gov/contact/index.html

Vermont

Vermont Department of Health
108 Cherry Street
Burlington, VT 05402
Phone: (802) 863-7200 or (800) 464-4343, TTY/TDD: Dial 711 first
Fax: (802) 865-7754
Website: http://healthvermont.gov/contact/contact.aspx

Virginia

Virginia Department of Health
109 Governor Street
Richmond, VA 23219
Phone: (804) 864-7001
Website: http://www.vdh.state.va.us/

Washington

Washington State Department of Health
101 Israel Rd SE
Tumwater, WA 98501

Or

P.O. Box 47890
Olympia, Washington 98504-7890
Phone: (360) 236-4030
Website: http://www.doh.wa.gov/

Washington D.C.

Dept. of Health
Government of the District of Columbia
899 North Capitol Street NE
Washington, DC 20002
Website: http://doh.dc.gov

West Virginia

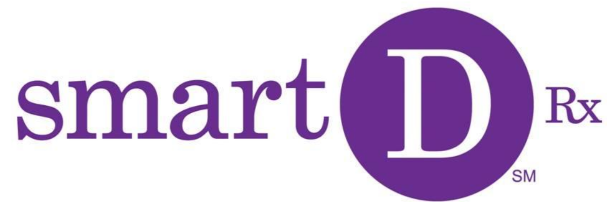
West Virginia Department of Health & Human Resources
One Davis Square, Suite 100 East
Charleston, WV 25301
Phone: (304) 558-0684
Fax: (304) 558-1130
Website: http://www.wvdhhr.org/

Wisconsin

Department of Health Services
1 West Wilson Street
Madison, WI 53703
Phone: (608) 266-1865
Website: http://www.dhs.wisconsin.gov/

Wyoming

Wyoming Department of Health
401 Hathaway Building
Cheyenne, WY 82002
Phone: (307) 777-7656 or (866) 571-0944
Fax: (307) 777-7439
Website: http://www.health.wyo.gov/default.aspx



SmartD Rx Saver (PDP) Member Services

CALL	1-855-976-2781 Calls to this number are free. 24 hours a day, 7 days a week Member Services also has free language interpreter services available for non-English speakers.
TTY	1-888-328-0419 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week
FAX	1-888-328-0418
WRITE	SmartD Rx P.O. Box 1417 Mechanicsburg, PA 17055 Email: info@smartdrx.com
WEBSITE	www.smartdrx.com

State Health Insurance Assistance Program

Please reference Exhibit B on page 125 for the applicable State Health Insurance Assistance Program (SHIP).