FirstUA Medicare Part D

Prescription Drug Coverage

EVIDENCE OF COVERAGE

Your Medicare prescription drug coverage as a Member of First UA Medicare Part D Prescription Drug Coverage

January 1 – December 31, 2008

This booklet gives the details about your Medicare prescription drug coverage and explains how to get the prescription drugs you need. It is an important legal document. Please keep it in a safe place.

First UA Medicare Part D Customer Service:

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

Calls to these numbers are free:

Phone: **1-866-529-4171**

TTY/TDD: **1-866-524-4172**

Hours of Operation: 8:00am to 8:00pm Eastern.

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Section 1 Introduction

Contact Information

Telephone numbers and other information for reference

How to contact our Plan Customer Service

If you have any questions or concerns, please call or write to our Plan Customer Service. We will be happy to help you. For help or information, please call Customer Service seven days a week, from 8am to 8pm Eastern, November 15, 2007 through March 1, 2008. A customer service representative will be available to answer your call directly. However, after March 1, 2008, on, your call will be handled by our automated phone system, in which you will be able to leave a message. When leaving a message, please include your name, number and the time that you called, and a representative will return your call the next business day.

CALL 1-866-529-4171.
This number is also on the cover of this booklet for easy reference.
Calls to this number are free.

TTY/TDD 1-866-524-4172.
This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

FAX 1-972-569-3709

WRITE First United American Life Insurance Company, P.O. Box 8080, McKinney, TX 75070,
or e-mail medicarepartd@firstunitedamerican.com

VISIT First United American Life Insurance Company
1020 Seventh North Street, Liverpool, NY 13088

WEBSITE www.firstuamedicarepartd.com

Contact Information for Grievances, Coverage Determinations and Appeals

Part D Coverage Determinations

CALL 1-866-529-4171.
This number is also on the cover of this booklet for easy reference.
Calls to this number are free.

If you are requesting a decision outside of normal business hours, be sure to call us at 1-800-753-2851 and listen to the recording for further instructions.

TTY/TDD 1-866-524-4172.
This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

FAX 1-888-235-8551

WRITE First United American Life Insurance Company, P.O. Box 8080, McKinney, TX 75070,
or e-mail medicarepartd@firstunitedamerican.com

For information about Part D coverage determinations, see Section 8.

Part D Grievances

CALL 1-866-529-4171.
This number is also on the cover of this booklet for easy reference.
Calls to this number are free.

If you are requesting a decision outside of normal business hours, be sure to call us at 1-800-753-2851 and listen to the recording for further instructions.

TTY/TDD 1-866-524-4172.
This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

FAX 1-888-235-8551

WRITE Medco Health Solutions, 8111 Royal Ridge Parkway, Irving, TX 75063.

For information about Part D grievances, see Section 7.

Part D Appeals

CALL 1-866-529-4171.
This number is also on the cover of this booklet for easy reference.
Calls to this number are free.

If you are requesting a decision outside of normal business hours, be sure to call us at 1-800-753-2851 and listen to the recording for further instructions.

TTY/TDD 1-866-524-4172.
This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

FAX 1-888-235-8551

WRITE Medco Health Solutions, 8111 Royal Ridge Parkway, Irving, TX 75063.

For information about Part D appeals, see Section 8.

HICAP – a state program that gives free local health insurance counseling to people with Medicare

Health Insurance Information Counseling and Assistance Program (HIICAP) is the State health Insurance Assistance Program (SHIP) for the State of New York, paid by the Federal government to give free health insurance information and help to people with Medicare. HIICAP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HIICAP has information about Medicare Prescription Drug Plans, Medicare Health Plans, and about Medigap (Medicare supplement insurance) policies.

You can contact HIICAP at Health Insurance Information Counseling and Assistance Program
2 Empire State Plaza, Agency Bldg. #2
New York City, NY 12223
Tollfree: 1-800-701-0501
Fax: 1-518-486-2225
Hours: 9:00 am - 3:00 pm (M-F)
Web site:
http://www.hiicap.state.ny.us/

You may also find the Web site for your local SHIP at www.medicare.gov on the Web. Under "Search Tools," select "Helpful Phone Numbers and Websites."

IPRO – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

In New York, there is a Quality Improvement Organizarion called Island Peer Review Organization (IPRO). IPRO is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in IPRO review written quality of care complaints made by Medicare patients. See Section 6 for more information about complaints.

You can find contact IPRO at Island Peer Review Organization
1979 Marcus Avenue, Suite 105
Lake Success, NY 11042
Local: 1-516-326-7767
Tollfree: 1-800-331-7767
Web site: www.ipro.org

How to contact the Medicare program

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare Plans (including our Plan).

Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov. This is the official government Web site for Medicare information. This Web site gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Web sites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

Other organizations (including Social Security and Medicaid - a state government agency that handles health care programs for people with limited resources)

Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact:

NY State Dept. of Health
Office of Medicaid Management
Governor Nelson A. Rockefeller Empire State Plaza,
Corning Tower Building
Albany, NY 12237
local: 1-518-486-9057
toll-free: 1-800-541-2831
fax: 1-518-486-6852

Social Security

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

EPIC - Qualified State Pharmacy Assistance Program

Some states have State Pharmacy Assistance Programs (SPAPs). Elderly Pharmaceutical Insurance Coverage (EPIC) is a state-funded program that provides financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. EPIC may help pay for the premiums and/or co-payments/co-insurance for those who qualify. In addition, payments made by Qualified SPAPs on your behalf for copayments, coinsurance, may help you qualify for catastrophic coverage. Please contact a SPAP in your state to determine what benefits may be available to you.

You can contact EPIC at:

Elderly Pharmaceutical Insurance Coverage (EPIC)
P.O. Box 15018
Albany, NY 12212-5018
Phone (In State): 1-800-332-3742
TTY 1-800-290-9138
http://www.health.state.ny.us/health_care/epic/

Railroad Retirement Board

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

Employer (or "Group") Coverage

If you or your spouse get your benefits from your current or former employer or union, or from your spouse's current or former employer or union, call your employer's or union's benefits administrator or Customer Service if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouse's) employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enrolls in Medicare Part D. Call your employer's or union's benefits administrator or Customer Service to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

Welcome to First UA Medicare Part D Prescription Drug Coverage!

We are pleased that you've chosen our Plan.

First UA Medicare Part D is a Medicare Prescription Drug Plan.

Thank you for your membership in First UA Medicare Part D; you are getting your Medicare prescription drug coverage through our Plan. First UA Medicare Part D is not a "Medigap" Medicare Supplement Insurance policy.

Throughout the remainder of this Evidence of Coverage, we refer to First UA Medicare Part D as "Plan" or "our Plan."

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

This Evidence of Coverage, together with your enrollment form, riders, Annual Notice of Change (ANOC), formulary, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. The information in this Evidence of Coverage is in effect for the time period from January 1, 2008, - December 31, 2008.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get your prescriptions filled including some rules you must follow.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave our Plan

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

Eligibility Requirements

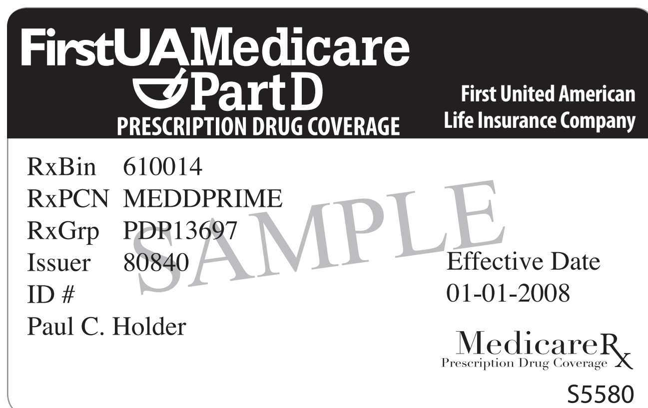
To be a member of our Plan, you must live in our service area and either be entitled to Medicare Part A or be enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare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

Use your plan membership card, not your red, white, and blue Medicare card

Now that you are a member of our Plan, you must use our membership card for prescription drug coverage at network pharmacies. While you are a member of our Plan and using our Plan services, you must use your plan membership card instead of your red, white, and blue Medicare card to get covered drugs.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered drugs. If your membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Here is a sample card to show you what it looks like:



SAMPLE

MEMBERS: This card must be presented at a participating pharmacy when purchasing prescription drugs.

SUBMIT CLAIMS TO
Medco Health Solutions, Inc.
PO Box 14718
Lexington, KY 40512

IMPORTANT NUMBERS
Customer Service 1-866-524-4171
TTY/TDD **1-866-524-4172**
Provider Line **1-800-922-1557**
www.firstuamedicarepartd.com

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

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

Explanation of Benefits

What is the Explanation of Benefits?

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

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary affecting the prescriptions you have gotten filled that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
    - **Amount Paid For Prescriptions -** The amounts paid that count towards your initial coverage limit.

- **Total Out-Of-Pocket Costs That Count Toward Catastrophic Coverage -** The total amount you and/or others have spent on prescription drugs that count towards your qualifying for catastrophic coverage. This total includes the amounts spent for your co-payment and coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

What should you do if you don't get an Explanation of Benefits or if you wish to request one?
An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

The geographic service area for our Plan.

The states in our service area are: The State of New York.

If you move into a state not listed above, please call Customer Service to find out if we have a plan in your new state.

Section 2 How You Get Outpatient Prescription Drugs (Part D)

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in an SPAP, you may get help paying your premiums and co-insurance/co-payments. Please contact your SPAP to determine what benefits are available to you. *Please see the Introduction section for more information.*

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

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

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If you are a member of an employer or retiree group

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

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

Using network pharmacies to get your prescription drugs covered by us

What are network pharmacies?

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

- **What is a "network pharmacy"?** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drug. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you aren't required to continue going to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.
- **What are "covered drugs"?** The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

How do you fill a prescription at a network pharmacy?
To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call 1-800-922-1557 to obtain the necessary information to pay the full cost of the prescription (rather than paying just your co-payment or coinsurance). If this happens, you may ask us to reimburse you for our share of the cost by submitting a claim to us. *To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"*

What if a pharmacy is no longer a network pharmacy?
Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Customer Service to find another network pharmacy in your area.

How do you fill a prescription through our Plan's network mail-order-pharmacy service?
You may use our network mail-order-pharmacy service to fill prescriptions for "maintenance drugs." These are drugs that you take on a regular basis for a chronic or long-term medical condition.

When you order prescription drugs through our network mail-order-pharmacy service, you must order a 90 day supply of the drug.

Generally, it takes us 3 to 5 days to process your order and ship it to you. However, sometimes your mail order may be delayed. Make sure you have at least a 14-day supply of that medication on hand. If your mail-order shipment is delayed, please call 1-800-473-3455 (TTY/TDD users should call 1-800-716-3231). The customer service representative will work with you to acquire a supply of your prescription at your convenience. The customer service representative can contact the prescribing physician for an emergency supply, as well as the pharmacy of your choice, and will provide assistance in resolving utilization management rejections that may occur. We'll make sure you have your medication when you need it.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies. Some retail pharmacies may agree to accept the mail order co-payment for an extended supply of medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may provide an extended supply, but charge a higher co-payment than our mail order service. Please call our Customer Service to find out which retail pharmacies offer an extended supply.

Filling prescriptions outside the network

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription.** If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay will help you qualify for catastrophic coverage.

Note: If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

Other times you can get your prescriptions covered if you go to an out-of-network pharmacy

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).

- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B and some covered drugs that are administered in your doctor's office.

How do you submit a paper claim?

When you go to a network pharmacy and use your membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. When you return home, go to www.firstuamedicarepartd.com on the Internet, click on the Useful Forms button and download a Direct Claim Form, or contact Customer Service and they will mail you one. Simply submit your claim and your receipt to the following address: Medco Health Solutions, Inc., PO Box 14718, Lexington, KY 40512. Upon receipt, we will make an initial coverage determination on the claim. *Please refer to Section 8 or contact Customer Service for more information on initial coverage determinations*.

If you submit a paper claim to us, the claim is treated as a request for a coverage determination. If you are asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. *See Section 8 to learn more about requesting coverage determinations*.

If you submit a paper claim asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. *See Section 8 to learn more about requesting coverage determinations*.

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

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we should cover your prescription drugs, we will cover them as long as the drugs meet all coverage requirements are met (such as the drugs being on our formulary, filled at a network pharmacy, etc.) and they aren't covered by Medicare Part A or Part B. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network), unless you meet standards for out-of–network care, and that the drugs wouldn't otherwise be covered by Medicare Part B. When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Advantage or Prescription Drug Plan.

Long-term care pharmacies

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

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies
Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through First UA Medicare Part D's pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies).

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Customer Service.

Home infusion pharmacies
Our plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug,
- Your prescription drug is not otherwise covered under Medicare Part B,
- Our plan has approved your prescription for home infusion therapy, and
- Your prescription is written by an authorized prescriber.

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

Some vaccines and drugs may be administered in your doctor's office
We may cover vaccines that are preventive in nature (including the cost associated with administering the vaccine) and aren't already covered by Medicare Part B. This coverage includes the cost of vaccine administration.
(Please see Section 3, "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail-order-pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under "Utilization Management."

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active ingredient as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits Medicare coverage of certain types of drugs. *(See Section 6 for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.)* In other cases, we have decided not to include a particular drug on our formulary.

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

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

You may call Customer Service to find out if your drug is on the formulary or to request a copy of our formulary. You may also get updated information about the drugs covered by us by visiting our Website www.firstuamedicarepartd.com.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance/cost-sharing depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. *See Section 8 to learn more about how to request an exception.*

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, add prior authorizations, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60 day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to an appropriate drug that we cover or request a formulary exception before the change to the formulary takes effect. If a drug is removed from our formulary because the drug

has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members taking the drug about the change as soon as possible.

What if your drug isn't on the formulary?

If your prescription isn't listed on the formulary, you should first contact Customer Service to be sure it isn't covered.

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

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service or go to our formulary Web site www.firstuamedicarepartd.com.
2. You may ask us to make an exception (which is a type of coverage determination) to cover your drug. *See Section 8 to learn more about how to request an exception.*
3. You can pay out-of-pocket for the drug and request that the Plan reimburse you by requesting an exception (which is a type of coverage determination). This doesn't obligate the Plan to reimburse you if the exception request isn't approved. If the exception isn't approved, you may appeal the Plan's denial. *See Section 8 for more information on how to request an appeal.*

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it isn't on our formulary.

Transition Policy

New members in our Plan may be taking drugs that aren't in our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. *See Section 8 (under "What is an exception?") to learn more about how to request an exception.* Please contact Customer Service if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year, and you need help switching to an appropriate drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year and provide you with the opportunity to request a formulary exception in advance for the following year.

For each of the drugs that isn't on our formulary or that has coverage restrictions or limits, we will cover a temporary 34-day supply (unless the prescription is written for fewer days) when a new or current member goes to a network pharmacy (and the drug is otherwise a "Part D drug"). After we cover the temporary 34-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 34-day transition supply (unless you have a prescription written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan, when that member is a resident of a long-term-care facility. If a new member, who is a resident of a long-term-care facility and has been enrolled in our Plan

for more than 90 days, needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and that are bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out-of-network, unless you qualify for out-of-network access.

Reimbursing Plan Members for Coverage During Retroactive Periods

If you were automatically enrolled in our Plan because you were Medicaid eligible, your enrollment in our Plan may be retroactive back to when you became eligible for Medicaid. Your enrollment date may even have occurred during the prior year. In order to be reimbursed for expenses you incurred during this time period (and that were not reimbursed by other insurance), you must submit a paper claim to us *(See "How do you submit a paper claim" in Section 2)*. We are required to have a seven-month special transition period that allows us to cover most of your claims from the effective date of your enrollment to the current time; however, depending upon your situation, you or Medicare may be responsible for any out-of-network or price differentials. You may also be responsible for some claims outside of the seven-month special transition period if the claims are for drugs not on our formulary. For more information, please call Customer Service.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members.

The requirements for coverage or limits on certain drugs are listed as follows:

- **Prior Authorization:** First UA Medicare Part D requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from First UA Medicare Part D before you fill your prescriptions. If you don't get approval, First UA Medicare Part D may not cover the drug.
- **Quantity Limits:** For certain drugs, First UA Medicare Part D limits the amount of the drug that First UA Medicare Part D will cover. For example, First UA Medicare Part D provides 34 tablets per prescription for LIPITOR. This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, First UA Medicare Part D requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, First UA Medicare Part D may not cover drug B unless you try Drug A first. If Drug A does not work for you, First UA Medicare Part D will then cover Drug B.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary on our formulary Web site or by calling Customer Service. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). *See Section 8 for more information about how to request an exception.*

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors

- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan doesn't affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan. In addition, if your drug would be covered by Medicare Part A or Part B, it can't be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this Plan (Medicare Part D) in other cases but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

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

Paying your monthly plan premium

As a member of First UA Medicare Part D you must pay a monthly plan premium, unless you qualify for extra help from Medicare.

Monthly Plan Premium: $39.20

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

Note: If you are getting extra help with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs". Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP to determine what benefits are available to you. *Refer to Section 1*.

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

There are two ways to pay your monthly plan premium.

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

You can decide to pay your premium directly to our Plan with a check or money order.

For your convenience, we will provide premium statements approximately 10 days prior to the date each premium is due. Simply mail the return portion of each statement with your check made payable to First United American Life Insurance Company, P.O. Box 268873, Oklahoma City, OK 73126-8873. Envelopes for mailing are provided with each statement. Premiums can be paid monthly, quarterly, semi-annually or annually for the 2008 plan year. Payments must be received by the 5th of the month to be reflected on the next month's statement.

Instead of paying by check, you can have your premium automatically withdrawn via electronic funds transfer on a monthly basis from your bank account on the date you choose. If you did not choose this option at the time of your enrollment, you may still choose this method. Just complete the bank draft authorization form found in your billing notice from us, or you can contact Customer Service and they will send you a form.

Option two: You can have your monthly plan premium directly deducted from your monthly Social Security check.

You can choose this option if you can pay for the entire Medicare premium with your Social Security check. Contact Customer service for more information on how to pay your premium this way.

Note: We do not recommend that you choose this option if you are receiving assistance for your premium payment from another payer, like a State Pharmaceutical Assistance Program (SPAP). Social Security can only withhold the full amount of the premium and will not recognize any premium payments made by other payers as part of this process.

Can your premiums change during the year?

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

In certain cases, your Plan premium may change during the calendar year. If you aren't currently getting extra help, but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your Plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or resources or if you get married or become single during the year. If

the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. Social Security or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help *(see contact information in Section 1)*.

What happens if you don't pay your plan premiums, or don't pay them on time?

If your plan premiums are past due, we will tell you in writing when a 60-day grace period begins. Failure to pay your past-due plan premiums within the 60-day grace period will result in your disenrollment. Disenrollment ends your membership in our Plan. If you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Election Period, unless you qualify for a Special Enrollment Period. If you do not have another source of creditable prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage. If you should decide to re-enroll in this Plan during the next Annual Coordinated Election Period, or to enroll in another plan offered by us, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in our Plan.

Paying your share of the cost when you get covered drugs

What are "co-payments," and "coinsurance"?

- A **"co-payment"** is a payment you make for your share of the cost of certain covered drugs you get. A co-payment is a set amount per drug. You pay it when you get the drug. Co-payments for prescription drugs are listed later in this section.
- "**Coinsurance"** is a payment you make for your share of the cost of certain covered drugs you receive. Coinsurance is a percentage of the cost of the drug. You pay your coinsurance when you get the drug. If you take a drug listed in Tier 4 on our Formulary, you will pay 25% coinsurance. Coinsurance for prescription drugs is listed later in this section.

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

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see "Do you qualify for extra help?" later in this section, and the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs."

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage period, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below.

Initial Coverage Period

During the initial coverage period, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the coinsurance/co-payment. Your coinsurance/co-payment will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs*:

Drug Tier	Retail In-Network Pharmacy Co-payment/ Co-insurance (34-day supply)	Retail In-Network Pharmacy Co-payment/ Co-insurance (90-day supply)	Retail Out-of-Network Pharmacy Co-payment/ Co-insurance (34-day supply)	Mail Order Co-payment/ Co-insurance (90-day supply)
Tier 1 - Formulary Generic Brand	$9	$23	$9	$18
Tier 2 - Formulary Preferred Brand	$37	$93	$37	$74
Tier 3 - Formulary Non-Preferred Brand	$74	$185	$74	$148
Tier 4 - Specialty Brand	33%	33%	33%	33%

*** Amounts in this chart may vary according to your individual out-of-network cost-sharing responsibility.**

Once your total drug costs reach $2,510, you will reach your initial coverage limit. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

Coverage Gap

After your total drug costs reach $2,510 you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach $4,050, and you qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $4,050 out-of-pocket for the year. When the total amount you have paid toward your co-payments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,050, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of $2.25 for generics or drugs that are treated like generics and $5.60 for all other drugs or 5% coinsurance. We will pay the rest.

Vaccines (including administration)

Our plan's prescription drug benefit covers a number of vaccines (including vaccine administration). The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, and then you will be reimbursed. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

Remember you are responsible for all of the costs associated with vaccines (including their administration) during any coverage gap phases of your benefit.

If you obtain the vaccine at:	And get it administered by:	You pay (and are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay co-payment/coinsurance
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less co-payment/coinsurance plus any difference between the amount the Doctor charges and what we normally pay. Or, if your doctor agrees to submit your claim on your behalf, you pay co-payment/coinsurance plus any difference between the amount the Doctor charges and what we normally pay.*
The Pharmacy	Your Doctor	You pay co-payment/coinsurance at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the latter amount less co-payment/coinsurance plus any difference between what the Doctor charges for administering the vaccine and what we normally pay.*

* If you receive extra help, we will reimburse you for this difference.

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

How is your out-of-pocket cost calculated?

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

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- Your coinsurance or co-payments;
- Payments you make after the initial coverage limit.

When you have spent a total of $4,050 for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs will not count toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan;
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.

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

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

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

Payments made by the following **don't count** toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, every month you purchase covered prescription drugs through us, you will get an

Explanation of Benefits that shows your out-of-pocket cost amount to date.

What extra help is available?

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's monthly premium and prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.
2 **You apply and qualify.** You may qualify if your yearly income in 2007 is less than $15,315 (single with no dependents) or $20,535 (married and living with your spouse with no dependents), and your resources are less than $11, 710 (single) or $23, 410 (married and living with your spouse). Resources include your savings and stocks but not your home or car. **If you think you may qualify, call Social Security at 1-800-772-1213, visit**

www.socialsecurity.gov on the Web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2007 and will change in 2008. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium and prescription co-payments. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs".

What if you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount?

If you believe you **have qualified** for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to provide evidence of your proper co-payment level.:

- Call Customer Service at 1-866-529-4171 (TTY/TDD users should call 1-866-524-4172) from 8:00am to 8:00pm Eastern; or
- Mail a copy of your current award letter from the Social Security Administration to:
  Part D Customer Service, P.O. Box 8080, McKinney, TX 75070; or
- Fax a copy of your current award letter from the Social Security Administration to 1-972-569-3709.

Please be assured that if you overpay your co-payment, we will generally reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy hasn't collected a co-payment from you and is carrying your co-payment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

Using all of your insurance coverage

If you have additional prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the drug benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You are required to tell our Plan if you have additional drug coverage

Important Information about Medicare Prescription Drug Coverage

We will send you a Coordination of Benefits (COB) Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional drug coverage, you are required to provide that information to our Plan. **The information you provide helps us calculate how much you and others have paid for your prescription drugs.** In addition, if you lose or gain additional prescription drug coverage, please call Customer Service to update your membership records.

You must tell us if you have any other prescription drug coverage besides our Plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage you might have include the following:

- Coverage that you have from an employer's group health insurance for employees or retirees, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (veteran's benefits).
- Coverage you have for dental insurance.
- Coverage you have for prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and you go without creditable prescription drug coverage (as good as Medicare's) for 63 continuous days or more, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006 and/or 2007, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2007, the national base beneficiary premium is $27.35). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

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

You won't have to pay a late enrollment penalty if:

- You had creditable prescription drug coverage (as good as Medicare's)
- The period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You prove that you were not informed that your prescription drug coverage was not creditable
- You lived in an area affected by Hurricane Katrina AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help AND you join a Medicare prescription drug plan by December 31, 2007, AND you stay in a Medicare prescription drug plan

Your late enrollment penalty may be reduced or eliminated if:

- You receive extra help in 2008 or after

Section 5 Your rights and responsibilities as a member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and, we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "find a Medicare Publication." If you have any questions whether our Plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our Plan, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Customer Service at the phone number in Section 1. Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call the Office for Civil Rights in your area:

OCR of New Jersey, New York, Puerto Rico, and Virgin Islands
26 Federal Plaza, Suite 3312
New York, NY 10278
Local: 1-212-264-3313
Tollfree: 1-800-368-1019
TTY: 1-212-264-2355
Fax: 1-212-264-3039
Hours: 8:30am-5:00PM
Web site: www.hhs.gov/ocr

Your right to the privacy of your medical records and personal health information

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

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service at the phone number in Section 1 of this booklet. The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

Your right to get your prescriptions filled within a reasonable period of time
You have the right to timely access to your prescriptions at any network pharmacy.

Your right to make complaints
You have the right to make a complaint if you have concerns or problems related to your coverage. A complaint can be called a grievance or a coverage determination depending on the situation. *See Section 8 for more information about complaints.*

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Customer Service.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Service at the number in Section 1 of this booklet. You can also get free help and information from your SHIP (contact information for your SHIP in Section 1 of this booklet). You can also visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?
If you think you have been treated unfairly or your rights have not been respected, you may call Customer Service or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights *(See previous page).*
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP *(contact information for your SHIP is in Section 1 of this booklet).*

Your right to get information about your drug coverage and costs
This EOC tells you what you have to pay for prescription drugs as a member of our Plan. If you need more information, please call our Customer Services numbers in Section 1. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. *See Section 8 for more information about filing an appeal.* You also have the right to receive an explanation from us of any utilization-management requirements, such as step therapy or prior authorization that may apply to your plan. If you have any questions please review our formulary Web site or call Customer Service.

Your right to get information about our Plan and our network pharmacies
You have the right to get information from us about our Plan. This includes information about our financial condition and about our network pharmacies. *To get any of this information, call Customer Service at the phone number shown in Section 1.*

Introduction

The purpose of this section is to tell you about drugs that are "excluded," meaning they aren't normally covered by a Medicare Prescription Drug Plan.

If you get drugs that are excluded, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 8).

Drug exclusions

A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B. Also, while a Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted.[1] If the use is not supported by one of these reference books (known as compendia), then the drug is considered a non-Part D drug and cannot be covered by our Plan.

By law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines
Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction	

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

Section 7 How to file a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for a coverage determination, or an appeal, as described in Section 8 of this manual because grievances do not involve problems related to approving or paying for Part D benefits.

If we will not give you the drugs you want, you must follow the rules outlined in Section 8.

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

- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the service you receive from Member Service.
- Problems with how long you have to wait in a network pharmacy.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- Cleanliness or condition of network pharmacies.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in more detail in Section 8.
- You believe our notices and other written materials are hard to understand.
- We don't give you a decision within the required time frame (on time).
- We don't give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss fast grievances in more detail in Section 8.

Filing a grievance with our Plan

If you have a complaint, please call the phone number for **Part D Grievances** in Section 1 of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this formal procedure First UA Medicare Part D's Grievance Review.** When your grievance cannot be resolved by phone, you should write to First UA Medicare Part D Grievance Review, P. O. Box 8080, McKinney, TX 75070. Your letter should state the nature of the grievance including the name of the person or pharmacy with whom you have a grievance and the date of the occurrence, or other details as appropriate.

You have the right to ask for a "fast grievance" review. This means we will make a determination regarding your grievance within 24 hours of receipt. You should mark your letter "fast grievance" if you are requesting this procedure. If we determine that a "fast grievance" review is not appropriate, we will notify you immediately and your grievance will be handled within the normal time frames outlined below.

Depending on the nature of your grievance we may ask for additional information from you or the party named in your grievance. If we need additional information, that information will be requested within 5 days of receipt of your grievance. Upon receipt of the additional information, we will make a determination within 30 days.

If we resolve your grievance in your favor, you will be notified immediately upon determination, but no later than 30 calendar days after receiving your complaint.

If your grievance is not resolved in your favor, you may ask for a reconsideration. You can ask for a reconsideration by writing First UA Medicare Part D's Grievance Review, P. O. Box 8080, McKinney, TX 75070. Your letter should state the nature of the grievance, a copy of our notification to you regarding the grievance, and the reasons supporting your request for a reconsideration. Your reconsideration request will be reviewed and a notification will be mailed to you within 30 days of receipt. This procedure does not guarantee that a resolution will be made in your favor.

We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization QIO, or both. If you file with the QIO, we must help the QIO resolve the complaint. *See Section 1 for more information about the QIO, and refer to Section 1 for the QIO in your area.*

How to file a quality of care complaint with the QIO

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. *See Section 1 for more information about how to file a quality of care complaint with the QIO.*

Section 8 What to Do if You have Complaints about Your Part D Prescription Drug Benefits

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Customer Service at the number in Section 1 of this booklet.

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

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

A **grievance** is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. *For more information about grievances, see Section 7.*

A **coverage determination** is the first decision we make about covering the drug you are requesting. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you may contact us if you want to request a coverage determination. For more information about coverage determinations and exceptions, see the section "How to request a coverage determination" below.

An **appeal** is any of the procedures that deal with the review of an unfavorable coverage determination. You cannot request an appeal if we have not issued a coverage determination. If we issue an unfavorable coverage determination, you may file an appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section "The appeals process" below.

How to request a coverage determination

What is the purpose of this section?

This part of Section 8 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What is a coverage determination?

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

The following are examples of coverage-determination requests:

- You ask us to pay for a prescription drug you have received. This is a request for a coverage determination about payment. You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision.

- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. *See "What is an exception" below for more information about the exceptions process.*
- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. *See "What is an exception" below for more information about the exceptions process.*
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. *See "What is an exception" below for more information about the exceptions process.*
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. *See "Filling Prescriptions Outside of Network" in Section 2 for a description of these circumstances.* You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

What is an exception?

An exception is a type of coverage determination. You may ask us to make an exception to our coverage rules in a number of situations.

- You may ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan that covers those excluded drugs.
- You may ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you may ask us to waive the limit and cover more. *See Section 4 ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs."*
- You may ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier (Tier 3), you may ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier (Tier 2) instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Brand tier (Tier 4).

Generally, we will only approve your request for an exception if the alternative drugs included on the Plan formulary or the drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment or coinsurance amount we require you to pay for the drug.

Who may ask for a coverage determination?
You, your prescribing physician, or someone you name may ask us for a coverage determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. This statement must be sent to us at the address listed under **Part D Coverage Determinations** in Section 1 of this booklet. To learn how to name your appointed representative, you may call Customer Service at the number in Section 1 of this booklet.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "standard" or "fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?
A decision about whether we will give you or pay for a Part D prescription drug can be a "standard" coverage determination that is made within the standard time frame (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is also called an "expedited coverage determination."

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

Asking for a standard decision
To ask for a standard decision, you, your doctor, or your appointed representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** in Section 1 of this booklet. Or, you can deliver a written request to the address listed in Section 1 or fax it to 1-888-235-8551. Our normal business hours are from 8:00am to 8:00pm Eastern. If you are requesting a decision outside of normal business hours, be sure to call (not fax) us at 1-800-753-2851, and listen to the recording for further instructions.

Asking for a fast decision
You, your doctor, or your appointed representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part D Coverage Determinations** in Section 1 of this booklet. Or, you can deliver a written request to the address listed in Section 1 or fax it to 1-888-235-8551. Our normal business hours are from 8:00am to 8:00pm Eastern. If you are requesting a decision outside of normal business hours, be sure to call (not fax) us at 1-800-753-2851, and listen to the recording for further instructions.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard time frame.

What happens when you request a coverage determination?

1. For a standard coverage determination about a Part D drug that includes a request to pay you back for a Part D drug that you have already received.

Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as dosage or quantity limits or step therapy requirements), we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

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

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

   If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review – sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

   If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens if we decide completely in your favor?

1. For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug that you have already received.

   We must give you the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must give you the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

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

   We must give you the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must give you the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If a coverage determination does not give you all that you requested, you have the right to appeal the decision. *(See Appeal Level 1.)*

The appeals process

This part of Section 8 explains what you can do if you disagree with our coverage determination.

What kinds of decisions can be appealed?

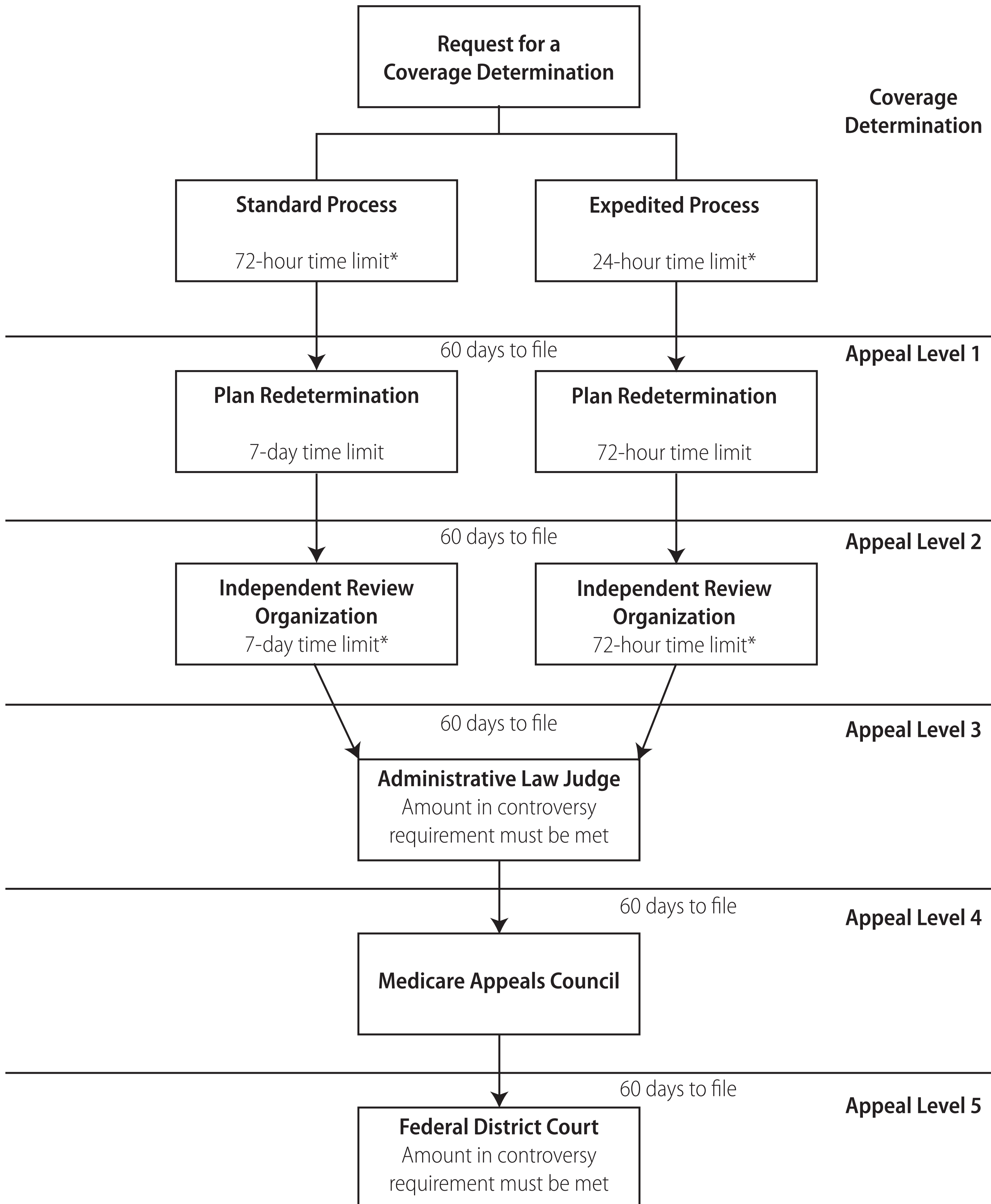
If you are not satisfied with our coverage determination decision, you may ask for an appeal called a "redetermination." You may generally appeal the following decisions:

- We do not cover a Part D drug you think you are entitled to receive,
- We do not pay you back for a Part D drug that you paid for,
- We paid you less for a Part D drug than you think we should have paid you,
- We ask you to pay a higher co-payment amount than you think you are required to pay for a Part D drug, or
- We deny your exception request.

How does the appeals process work?

There are five levels in the appeals process. At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may give you some or all of what you have asked for, or it may not give you anything you asked for. If you are unhappy with the decision, you may be able to appeal it and have someone else review your request.

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



*The adjudication time frames generally begin when the request is received by the Plan sponsor. However, if the request involves an exception to the Plan's formulary, the adjudication time frame begins when the Plan sponsor or independent review organization receives the doctor's supporting statement.

Appeal Level 1: If we deny any part of your request in our coverage determination, you may ask us to reconsider our decision. This is called a "request for redetermination."

You may ask us to review our coverage determination, even if only part of our decision is not what you requested. When we receive your request to review the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the coverage determination?

You or your appointed representative may file a **standard** appeal request.

You, your appointed representative, or your doctor may file a **fast** appeal request.

How soon must you file your appeal?

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

How to file your appeal

1. **Asking for a standard appeal**
   To ask for a standard appeal, you or your appointed representative may send a written appeal request to the address listed under **Part D Appeals** in Section 1 of this booklet. You may also ask for a standard appeal by calling us at the phone number shown under **Part D Appeals** in Section 1 of this booklet.
2. **Asking for a fast appeal**
   If you are appealing a decision we made about giving you a Part D drug that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** in Section 1 of this booklet. Our normal business hours are 8:00am to 8:00pm Eastern. If you are requesting a decision outside of normal business hours, be sure to call (not fax) us at 1-800-753-2851, and listen to the recording for further instructions. Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different. Appeal requests should be sent to Medco Health Solutions, 8111 Royal Ridge Parkway, Irving, TX 75063.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** in Section 1 of this booklet. You may also deliver additional information in person to the address listed under **Part D Appeals** in Section 1 of this booklet. You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** in Section 1 of this booklet. We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on your appeal?

1. For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.

   We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to the second level of appeal, where an independent review organization will review your case.

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

   We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens if we decide completely in your favor?

1. For a standard decision to pay you back for a Part D drug you already paid for and received.

   We must send payment to you no later than 30 calendar days after we receive your appeal request.

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

   We must give you the Part D drug you asked for within seven calendar days we receive your appeal request. We will give it to you sooner if your health requires us to.

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

   We must give you the Part D drug you asked for within 72 hours after we receive your appeal request. We will give it to you sooner if your health requires us to.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

Who may file your appeal?

You or your appointed representative may file a **standard** or **fast** appeal request.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days after the date you were notified of the decision on your first appeal. The independent review organization may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. **Asking for a standard appeal**

   To ask for a standard appeal, you or your appointed representative can send a written appeal request to the independent review organization at the address included in the redetermination notice you receive from us.

2. **Asking for a fast appeal**

   To ask for a fast appeal, you or your appointed representative may send a written appeal request to the independent review organization at the address included in the redetermination notice you receive from us. Remember, if your doctor provides a written or oral statement supporting your request for a fast appeal, the independent review organization will automatically give you a fast appeal.

How soon must the independent review organization decide?

1. For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug that you have already paid for and received.

   The independent review organization will give you its decision within seven calendar days after it receives your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

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

   The independent review organization will give you its decision within 72 hours after it receives your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already paid for and received.

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

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

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

If the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge if the dollar value of the Part D drug you asked for meets the minimum requirement provided in the independent review organization's decision. During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

Who may file your appeal?

You or your appointed representative may file an appeal request with an Administrative Law Judge.

How soon must you file your appeal?

The appeal request must be filed within 60 calendar days of the date you were notified of the decision made by the independent review organization (Appeal Level 2). The Administrative Law Judge may give you more time if you have a good reason for missing the deadline.

How to file your appeal

The request must be filed with an Administrative Law Judge in writing. The written request must be sent to the Administrative Law Judge at the address listed in the decision you receive from the independent review organization (Appeal Level 2).

The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?
If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes:

- Any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the Plan year,
- Your co-payments,
- All drug expenses after your drug costs exceed the initial coverage limit, and
- Payments for drugs made by other entities on your behalf.

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

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

How soon will the Judge make a decision?
The Administrative Law Judge will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:
The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.
2. For a standard decision about a Part D drug you have not received.

   We must give you the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.
3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 4: If an ALJ does not rule in your favor, your case may be reviewed by the Medicare Appeals Council

If the Administrative Law Judge does not rule completely in your favor, you or your appointed representative may ask for a review by the Medicare Appeals Council.

Who may file your appeal?
You or your appointed representative may request an appeal with the Medicare Appeals Council.

How soon must you file your appeal?
The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Administrative Law Judge (Appeal Level 3). The Medicare Appeals Council may give you more time if you have a good reason for missing the deadline.

How to file your appeal

The request must be filed with the Medicare Appeals Council. The decision you receive from the Administrative Law Judge (Appeal Level 3) will tell you how to file this appeal.

How soon will the Council make a decision?

The Medicare Appeals Council will first decide whether to review your case (it does not review every case it receives). If the Medicare Appeals Council reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 5: If the Medicare Appeals council does not rule in your favor, your case may go to a Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the Medicare Appeals Council decided not to review your appeal request.

Who may file your appeal?

You or your appointed representative may request an appeal with a Federal Court.

How soon must you file your appeal?

The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4).

How to file your appeal

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

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

How soon will the Judge make a decision?

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

If the Judge decides in your favor:

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you within 30 calendar days after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

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

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the appeal any further.

Section 9 Ending your Membership

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

- You might leave our Plan because you have decided that you want to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

In general, there are only certain times during the year when you may voluntarily end your membership in our Plan.

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

Outside of this time period, you generally can't make other changes during the year unless you meet special exceptions, such as if you move, if you have Medicaid coverage, or if you get extra help in paying for your drugs. For more information about these times and the options available to you, please refer to the "Medicare & You" handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to learn more about your options.

Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay for them yourself.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy or through our mail-order-pharmacy service, are listed on our formulary, and you follow other coverage rules."

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- **If you move out of the service area or are away from the service area for more than 6 months in a row.** If you plan to move or take a long trip, please call Customer Service to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you cannot remain a member of our Plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you).
- If you do *not* stay continuously enrolled in Medicare A or B (or both).
- If you intentionally provide false information on your enrollment request about other coverage you may have.
- If you behave in a way that is disruptive. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 60-day grace period during which you may pay the Plan premiums before your membership ends.

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

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

Section 10 Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of your state may apply.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Section 11 Definition of Some Words Used in This Book

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for a Part D drug benefit or payment for a Part D drug benefit you already received. There is a specific process that your Part D Plan Sponsor must use when you ask for an appeal. Section 8 explains what appeals are, including the process involved in making an appeal.

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

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,050 in covered drugs during the covered year. Please see Section 4 of this document.

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

Coverage Determination –A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

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

Creditable Prescription Drug Coverage - Prescription drug coverage (for example, from an employer or union) that is expected to pay as much as standard Medicare prescription drug coverage

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 9 discusses disenrollment.

Evidence of Coverage and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the Plan.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Grievance - A type of complaint you make about us or one of our Plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 8 for more information about grievances.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period after you have met your deductible (if you have one) and before your total drug expenses, have reached $2,510 including amounts you've paid and what our Plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

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

Medicare Advantage Plan with Prescription Drug Coverage –A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. A Medicare Advantage Plan can be an HMO, PPO, or a Private Fee-for-Service Plan.

Medicare Health Plan – A Medicare Advantage Plan (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plans that are offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

"Medigap" (Medicare Supplement Insurance) Policy - Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in the Original Medicare Plan. Medigap policies only work with the Original Medicare Plan.

Member (member of our Plan) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

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.

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 services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 2.

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

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs, see your formulary for a specific list of covered drugs. Certain categories of drugs, such as benzodiazepines and barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 6 for a listing of these drugs). These drugs are not considered Part D drugs.

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

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 approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a prescription drug sponsor.

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

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

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