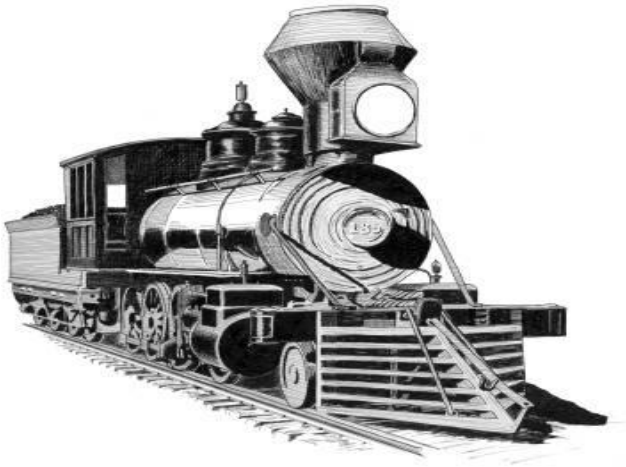

SFEHACL PART D MEDICARE PLAN (PDP) BENEFIT GUIDE

Your 2024 Medicare Prescription Drug coverage as a Member of the SFEHACL Part D Medicare Plan

A $9 copayment gets you a 90-day supply of any Tier 1 Generic drug from the Depot Drug Mail* Pharmacy while you are in your Initial Coverage benefit stage.

This Benefit Guide gives the details about your Medicare Prescription Drug coverage from January 1, 2024 through December 31, 2024. It may otherwise be known as your Evidence of Coverage (EOC). It is an important legal document. Please keep it in a safe place.

Benefits, formulary, pharmacy network, premiums, deductible, and/or copayments/coinsurance may change on January 1, 2024.

*Other pharmacies available in our network.

SFEHACL Customer Service

For help or information, please call Customer Service Monday through Friday from 7:30 am to 4:00 pm Pacific Time. Calls to this number are free:

1-877-968-3550

TTY/TDD Call the national number 711

MedicareRx
Prescription Drug Coverage

S8841EOC2024

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Important phone numbers and resources

How to contact the SFEHACL Customer Service

If you have any questions or concerns, please call or write to Customer Service. We will be happy to help you. Our Customer Service hours are 7:30 am to 4:00 pm, Pacific Time, Monday through Friday.

- **CALL** 1-877-968-3550, this number is also on the cover of this Benefit Guide for easy reference. Calls to this number are free.
- **TTY/TDD** Please use 711, the national access number.
- **FAX** 1-626-967-3161
- **WRITE OR IN PERSON** SFEHACL, 551 East San Bernardino Road, Covina, CA 91723
- **PART D DRUG APPEALS OR COVERAGE DECISIONS Call OptumRx, toll free at** 1-866-443-1095 or fax to them at 1-877-239-4565. Please use these numbers for the following:
    - When you want to contact us for a coverage decision about your Part D prescription drugs. A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs.
    - When you want to make an appeal about your Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made.
    - When you want to make a complaint about your Part D prescription drugs. You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve a coverage or payment dispute. If your problem is about our coverage or payment, refer to the text above about making an appeal.
    - When you want to send a request to ask us to pay for our share of the cost of a drug you have received. The coverage decision process includes determining requests that ask us to pay for our share of the costs of a drug that you have received. This may occur on Part D covered vaccinations, hospital take-home-drugs, or out-of-network pharmacy purchases.

Medicare

- **CALL** 1-800-Medicare, or 1-800-633-4227 calls to this number are free and available 24 hours a day, 7 days a week (TTY/TDD 1-877-486-2048)
- **WEBSITE** www.medicare.gov

Use a computer to look at www.medicare.gov, the official government Website for Medicare information**.** This Website gives you up-to-date information about Medicare and current issues. It includes Medicare publications you can print directly from your computer. It has tools to help you compare Medicare Health Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" Section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Website using their computer.

State Health Insurance Assistance Program (SHIP) – Free Help

State **H**ealth **I**nsurance Assistance **P**rogram or SHIP is a government program with trained counselors in every state. Counselors give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare Health Plans, and about Medigap (Medicare supplement insurance) policies.

- **CALL** Medicare at 1-800-633-4227 to find the SHIP in your state
- **WEBSITE** www.medicare.gov to find the SHIP in your state

Quality Improvement Organization

Quality **I**mprovement **O**rganization or QIO is a group of doctors and other health care experts paid by Medicare to check on the quality of care for people with Medicare. This is an independent organization that is not connected with SFEHACL. There is a QIO in each state. QIOs have different names, depending on which state they are in. You should contact your QIO if you have a complaint about the quality of care you have received. You can find contact information for the QIO in your state by calling Medicare at 1-800-633-4227.

Social Security Administration

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free and are available 7:00 AM to 7:00 pm, Monday through Friday. You can also visit http://ssa.gov.

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

Railroad Retirement Board

Most SFEHACL members receive their Medicare benefits through the Railroad Retirement Board. The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. You can call your local Railroad Retirement Board office or 1-877-772-5772 (calls to this number are free) from 9:00 AM to 4:00 PM, Monday through Friday. TTY/TDD users should call 1-312-751-4701. You can also visit https://secure.rrb.gov/.

State Pharmacy Assistance Program

Many states have **S**tate **P**harmacy **A**ssistance **P**rograms (SPAP's). SPAP's are State-funded programs that provide financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. Each state has different rules to provide drug coverage to its members. Some SPAP's will help pay for the premiums, deductibles, and/or copayments for those who qualify. Please contact the SPAP in your state to determine what benefits may be available to you. You can find the SPAP in your area by calling Medicare at 1-800-633-4227.

Medicaid

A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

To find out more about Medicaid and its programs, contact your specific state Medicaid office. You can find your state Medicaid office by calling Medicare at 1-800-633-4227.

Medicare's *Extra Help* Program

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

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for *Extra Help* and don't need to apply. Medicare mails a letter to people who automatically qualify for *Extra Help*. You may be able to get *Extra Help* to pay for your prescription drug premiums and costs. To see if you qualify for getting *Extra Help*, call:

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

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

- SFEHACL will apply an adjusted cost sharing amount using Best Available Evidence (BAE) that you provide prior to Medicare's notification to us. BAE would be a notice from your state Medicaid office or Medicare presented to the pharmacy or faxed to our Customer Service.
- When we receive the evidence showing your copayment level from Medicare or from you, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. We will forward a check to you in the amount of your overpayment. Please contact Customer Service if you have questions.

Section 1 Plan Basics

What is the SFEHACL Part D Medicare Prescription Drug Plan?

SFEHACL is an Employer Group Waiver Plan (EGWP) who has contracted with OptumRx, a pharmacy benefit manager, to administer your Medicare Part D Prescription Drug Plan. As an EGWP, our membership is available only to Santa Fe Railroad or affiliated Railroad Medicare retires, and their spouse/widow/widower. CMS does not require an EGWP to perform some of the contractual requirements that apply to for-profit Part D plans because of our membership restrictions. SFEHACL was founded solely to serve you - our members. Current SFEHACL Medicare members have been automatically enrolled in our Plan so that SFEHACL can continue to provide your prescription drug benefits while you receive Medicare benefits. Now that you are enrolled in the SFEHACL Part D Medicare Plan you are getting your Medicare Prescription Drug coverage through SFEHACL. This Benefit Guide explains your benefits, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare Prescription Drug coverage

Medicare Prescription Drug coverage is insurance that helps pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a contracted plan pharmacy, Medicare Part D covers it, and other coverage rules are followed. We do not pay for drugs under Medicare Part D that are covered by Medicare Part B. As a member, all you have to do is continue to pay your Part B premium and your SFEHACL monthly premium and copayments. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. If you have limited income and resources, you may get *Extra Help* from Medicare to pay your premium and copayments so that you get your prescription drugs for little or no cost. Please call Customer Service to learn more.

How other insurance works with our plan

If you have any other prescription drug coverage in addition to our plan, you are required to tell us. Please call Customer Service to let us know.

We are required to follow rules set by Medicare to make sure that you are using all of your benefits in combination when you get your covered drugs from our plan. This is called ***coordination of benefits*** because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it.

Medicare law requires us to collect this information from you when you or your spouse enrolls in the SFEHACL Medicare Plans, or when other insurance becomes involved.

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

- Veterans Administration. Medicare Part D does not coordinate with prescriptions supplied by the VA. Either the VA pays, or Medicare Part D pays, but not both.
- Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Customer Service at 1-877-968-3550 to update your membership records.

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 still qualify for Medicaid benefits.

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

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

If you have coverage from an AIDS Drug Assistance Program (ADAP)

What is the AIDS Drug Assistance Program (ADAP)? The **A**IDS **D**rug **A**ssistance **P**rogram (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

Help us keep your membership record up to date

We have a file of information about you as a plan member. Pharmacists use this membership record to know what drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage and other information.

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

What is the geographic service area for our Plan?

SFEHACL is a National Medicare Prescription Drug Plan and includes all 50 United States, the District of Columbia, Puerto Rico, and Guam. We cannot pay for any prescriptions that are filled by pharmacies outside of the United States, even for a medical emergency.

Use your SFEHACL ID Card for prescriptions instead of your Medicare card

As a member of our plan, one card does it for you! You have a combined SFEHACL Health Insurance and Rx ID card. Use your SFEHACL ID card to obtain prescriptions (not your Medicare card). However, you will need both your red, white and blue Medicare and SFEHACL ID cards for your medical service.

During the time, you are a plan member and using Plan Service, you *must* use your SFEHACL ID card. This ID card protects your privacy by using a SFEHACL unique ID number that we use to identify you. Your SFEHACL number is NOT your Social Security number or your Medicare Part A & B number. You must use your number on your card to identify yourself when obtaining prescriptions through the Depot Drug Mail Pharmacy and retail network pharmacies, and when contacting SFEHACL Customer Service. Please carry your Plan membership card with you at all times. If your membership card is ever damaged, lost, or stolen, call SFEHACL Customer Service right away and we will send you a new card.

Using plan pharmacies to get your prescription drugs covered by us

- **What is the Depot Drug Mail Pharmacy?** Depot Drug Mail Pharmacy provides prescriptions in 90-day supplies. You need to obtain 90-day supplies of all Tiers when using the Depot Drug Mail Pharmacy. If you need less than a 90-day supply, you must use a retail network pharmacy.

  Please Note: Other pharmacies are available within our network, but Depot Drug mail is the preferred mail-order pharmacy. Depot Drug mail does not dispense medications in certain states (listed below).

  Depot Drug is NOT Available in the following states: Alabama, Alaska, American Samoa, Connecticut, Delaware, District of Columbia, Guam, Hawaii, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Northern Mariana Islands, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, US Virgin Islands, Vermont, Virginia and West Virginia.

  OptumRx is the preferred mail-order pharmacy for the above states.

  OptumRx Member Services – 1-866-443-1095

- **What is a retail network pharmacy?** This is a pharmacy at which you can get prescriptions that you want in less than 90-day supplies. Copayments at these pharmacies are higher than those at Depot Drugs pharmacies. We call them retail network pharmacies because they are under contract with our plan. To verify if a pharmacy is in network, please contact member services at 1-866-443-1095 or visit our website at www.optumrx.com
- **What are covered drugs?** Most Medicare Part D covered drugs are included in our formulary. A covered drug is the general term we use to mean all of the outpatient prescription drugs that are covered by our plan and Medicare Part D.

How do I fill a prescription at a retail network pharmacy?

To fill your prescription at a retail network pharmacy, you must show your SFEHACL ID card. If you do not have your ID card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting your prescription receipt to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this Section.

Finding a retail network pharmacy

Most local and national chain pharmacies are in our retail pharmacy network. Since our plan is a national plan, all pharmacies cannot be listed in a directory. The pharmacist can tell you if their pharmacy is in network simply by showing them your SFEHACL ID card. You can call our Customer Service if you have questions.

What if your retail network pharmacy is no longer in our plan?

Very rarely a pharmacy might leave our network. If this happens, you will need to fill your prescriptions at another retail network pharmacy. Please call Customer Service to find another pharmacy in your area.

Getting new prescriptions from the Depot Drug Mail Pharmacy

There are some maintenance prescription drugs that cannot be sent through the mail. Depot Drug Mail Pharmacy does NOT supply those prescriptions. Please refer to your Formulary book and look for the BI (benefit indicator column). Then look for the **RO** (Retail Only) indicator. SFEHACL has determined that it is in your best interest to have these drugs supplied through your local retail network pharmacy and not in the mail.

- Depot Drug Mail Pharmacy can only ship 90-day supplies of Tier 1 generic prescription drugs. If you need less than a 90-day supply, you must use a retail network pharmacy. You may continue to obtain a 30, 60 or 90-day supply of Tier 2 or 3 prescription drugs.

Ordering new prescriptions is easy, and you are not charged shipping costs. Follow these directions to fill new prescriptions:

- Most physicians send prescriptions electronically (e-prescribe) to your preferred pharmacy. Your SFEHACL ID card includes Depot Drug Mail Pharmacy electronic prescribing information. They must follow Federal Medicare rules prohibiting automatically shipping when filling these prescriptions. They cannot fill prescriptions at all without your permission, so be sure to call Depot Drug Customer Service at 1-800-877-0618 when your doctor sends your new prescriptions electronically.
- If you mail a paper prescription to Depot Drug Mail, use a separate sheet of paper to show how many months supply you want, your name and SFEHACL ID card number exactly as they appear on your ID card, your return address, and your doctor’s name and telephone number with the area code. Remember, Depot Drug Mail Pharmacy fills only 3-month (90-day), or the amount left on your prescription for each Tier 1 generic drug prescription.
- Depot Drug Mail Pharmacy cannot fill your prescriptions sent by your doctor unless they have your specific authorization to do so. You need to call Depot Drug Customer Service 1-800-877-0618 to give this authorization when you know the doctor is sending a new prescription.
- Without copayment(s), your prescription(s) cannot be filled. You can pay by check or money order payable to the Depot Drug Mail Pharmacy. It is easier for you to pay your copayment with your debit or credit card. That way, you will not need to guess the amount of your copayment. To use your debit or credit card, write down the type of card (**MasterCard, Discover or VISA only**) and the entire debit or credit card number and expiration date of your card. Once your card number is on file with Depot Drug Mail Pharmacy, you do not need to send the number each time, but you must specifically authorize us to use your debit or credit card on file for your copayment to fill prescriptions.
- Allow ten (10) working days for mail delivery of your prescriptions. Debit or credit card payment is the most convenient way to pay your prescription copayments when you don’t know

how much to pay. We tell you how much we applied to your debit or credit card for your copayment on your receipt.

- Mail the prescription(s), your fill instructions, your personal information, and your applicable Tier copayment (or debit or credit card information and your authorization to charge your card) for the prescription(s) to: Depot Drug Mail Pharmacy, PO Box 165090, Salt Lake City, UT 84116-5090.

Refills by mail

Your prescriptions are easy to refill once they are already on file with the Depot Drug Mail Pharmacy. You must order a 90-day supply of Tier 1 generic prescription drugs, or the number of refill months left on your prescription. You may re-order another 3-month supply in 69 days, or more after your last 3-month refill so that you won't run out of your medication.

A convenient reorder form is included in each prescription sent to you. Simply indicate a one, two or three-month supply and your method of payment. If you are not using your debit or credit card, include a check or money order for your copayment and mail the form to the address indicated on the form. Mail the prescription(s) reorders, and your applicable Tier copayment (or debit or credit card information) for the prescription(s) to: Depot Drug Mail Pharmacy, PO Box 165090, Salt Lake City, UT 84116-5090 . You may call Depot Drug Customer Service at 1-800-877-0618.

Filling prescriptions outside the network

Before you fill your prescription outside the pharmacy network, call SFEHACL Customer Service to see if there is a retail network pharmacy in your area where you can fill your prescription. Failure to do so may cause your payment request to be denied. Generally, SFEHACL also limits the quantity of drugs covered out of network when approved. We will cover your prescription at an out of network pharmacy if at least one of the following applies:

- If you are trying to fill a prescription drug that is not regularly stocked at the Depot Drug Mail Pharmacy, or an accessible retail network pharmacy (including most specialty, high cost and unique drugs).
- If you are unable to obtain a covered drug in a timely manner because there is no retail network pharmacy within a reasonable driving distance that provides 24-hour service.
- If you are getting a covered vaccine that is medically necessary but not covered by Medicare Part B and/or some covered drugs that are administered in your doctor's office.
- Some hospital take-home drugs are covered by Part D.

If you do go to an out of network pharmacy for the reasons listed above, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim completed by the pharmacy and your receipt for the medication with a letter explaining your situation to SFEHACL. If you go to an out of network pharmacy, you are responsible for paying the applicable copayment and the difference between what we would have paid for the medication and what the out of network pharmacy charged for your medication. You should submit a claim to us if you fill a prescription at an out of network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see Section 3). To learn how to submit a request for payment, please refer to the process described next.

How do I submit a request for payment?

If you go to an out of network pharmacy because of the reasons listed above, the pharmacy will not be able to submit the claim directly to us and you will have to pay the full cost of your prescription. You may have the pharmacy submit your claim for you. Please submit your receipt and your letter explaining your situation to the following address:

OptumRx, Attn: Manual Claims, P.O. Box 650287, Dallas, TX 75265-0287

Upon receipt, an initial coverage decision will be made. If it is determined that the prescription should be covered, and the paper claims form is completed by the pharmacy, a payment for our cost of the drug minus the applicable copay amount will be mailed to you. All payment requests will be paid at the SFEHACL pharmacy contract rate and the applicable Tier co-payment will be applied based on your Part D benefit level. Payment could be denied if your receipt does not contain all of the information that Medicare requires for a coverage decision. (Please refer to Section 5 for more information about initial coverage decisions.)

To receive a coverage decision and possible payment for vaccine and administration costs from your physician that is not covered by Medicare Part B, please have your physician print, complete and mail the Prescription Drug Claim Form to SFEHACL. You may contact our Customer Service at 1-877-968-3550 if you have questions.

Home Infusion Pharmacies

It is our policy to contract with any willing Home Infusion Pharmacy that meets state, Federal and SFEHACL requirements to become a network HI Pharmacy. The SFEHACL Part D Medicare Plan will cover home infusion therapy if:

- Your prescription drug is on our formulary;
- Your prescription is written by an authorized prescriber; and
- You get your home infusion Service from a SFEHACL Home Infusion network pharmacy.

Long-term Care Pharmacies

SFEHACL has many Long-Term Care network pharmacies through our network that provide special Long-Term Care prescription dosing and packaging. SFEHACL has a national pharmacy network, but it is impossible for us to contract with every LTC pharmacy in the nation. It is our policy to contract with any willing LTC pharmacy that meets state, Federal and SFEHACL requirements to become a network LTC Pharmacy.

SFEHACL will cover Long Term Care drugs that are not obtained through either of these sources on a temporary basis if the need is urgent. 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 our network pharmacy and in limited areas.

It is our policy to contract with any willing I/T/U pharmacy that meets state, Federal and SFEHACL requirements to become a network pharmacy. Please contact Customer Service for more information.

What you pay for vaccinations covered by Part D

We cover a number of Part D vaccines. There are two parts to our coverage of vaccinations:

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

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

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

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

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

To show how this works, here are three common ways you might get a Part D vaccination shot:

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

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

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.

You can then ask our plan to pay our share of the cost by using the procedures for submitting a request for payment that is described in this Section of this booklet.

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

- You will have to pay the pharmacy the amount of your copayment for the vaccine serum itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in this Section.

You will be reimbursed the amount SFEHACL normally pays for the doctor to administer the vaccine.

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. We can tell you about how your vaccination is covered by our plan and explain your share of the cost.

Section 2 Plan Premium

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

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

2024 SFEHACL Part D Medicare Secondary Plan and Medicare Part D Prescription Plan members pay a combined premium for all Medicare Plans each month. Because the premiums are combined, SFEHACL members are not eligible for premium withhold from the RRB.

- SFEHACL charges a $20 service fee for any premium payments rejected for any reason.

There are two ways to pay your monthly plan premium

- **Option one – pay quarterly:** Pay your plan premium quarterly (3 months at a time) by check or money order, we must receive your payment on or before the first of the month of every January, April, July, and October beginning with January 1, 2024.
- **Option two – pay monthly:** Pay your premium monthly by check, money order or automatic premium deduction from your checking or savings account. If you choose automatic premium deductions, we will debit your account on the 15th day of every month.

If you have any questions about signing up for the automatic premium payment option, to receive an authorization form, please call our Customer Service at 1-877-968-3550.

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 within 15 days. Medicare requires us to disenroll you from our plan after the second month of failure to pay your past-due plan premiums. If you are disenrolled from SFEHACL for any reason including nonpayment of your premium, you may not have another opportunity to enroll again. Also, if you are disenrolled for this reason, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Enrollment Period, unless you qualify for a Special Enrollment Period. If you do not qualify for a Special Enrollment Period or have another source of creditable prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage. Please see Section 6 for more about enrollment periods.

You have to continue to pay your Part A and/or Part B premiums

To be a member of our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. You must pay your Part B premiums. If you currently pay a premium for Medicare Part A (most people don't) 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 our SFEHACL Medicare Plans.

Can your plan premiums change during the year?

Generally, SFEHACL cannot change your plan premium 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, 2024. Refer to your 2024 Annual Notice of Changes.

In limited circumstances, your plan premium may change during the calendar year. If you aren't currently receiving *Extra Help* but you qualify for it during the year, your monthly premium could be lower.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include *Extra Help* and State Pharmaceutical Assistance Programs. If you qualify, enrolling in one of these programs might lower your monthly plan premium. If you are already enrolled and getting help from one of these programs, the information about your premiums in this Benefit Guide may not apply to you.

In some situations, your plan premium could be more

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have *creditable* prescription drug coverage. (*Creditable* means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.

- If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

What is the late enrollment penalty?

You will have to pay a late enrollment penalty in addition to your monthly plan premium if both of the following two factors are present:

- You were eligible to enroll in a Medicare Prescription Drug Plan; and
- After the end of your initial enrollment period, there was a continuous period of 63 days or longer in which you were not enrolled in a Medicare Prescription Drug Plan or other creditable prescription drug coverage.
- *Creditable prescription drug coverage* is coverage that is at least as good as the standard Medicare Prescription Drug coverage that expects to pay, on average, at least as much as the Medicare Prescription Drug benefit expects to pay.
- You pay this late enrollment penalty for as long as you have Medicare Prescription Drug coverage. The amount of the late enrollment penalty may increase every year.
- The late enrollment penalty does not apply to individuals who qualify for Extra Help with their drug plan costs.

Who pays an extra Part D amount because of income?

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

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

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

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

The extra amount is paid directly to the government (not SFEHACL) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from SFEHACL Medicare plans and lose prescription drug coverage and your Medicare HCPP and Medicare Secondary Plan coverage. This disenrollment action is taken by Medicare.

Section 3 Prescription Drug Coverage

This Section describes your prescription drug coverage as a member of our plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is.

What is a formulary?

We have a formulary that lists all drugs that we cover. For 2024, we have included most Medicare Part D drugs in our formulary. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary; the prescription is filled through Depot Drug Pharmacy or at a retail network pharmacy, it is a covered Medicare Part D drug, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on certain drugs. These requirements and limits are described in detail in your Formulary Book and in this Section.

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

We have included most Medicare Part D covered drugs on our formulary. In some cases, the law prohibits us from covering certain types of drugs. See *Drug Exclusions*, later in this Section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.

In certain situations, prescriptions filled at an out of network pharmacy may also be covered. See Section 1 for more information about filling prescription at out of network pharmacies.

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

You have been sent a 2024 SFEHACL Part D Medicare Plan Drug Formulary Book with Tier 1, 2, 3 and 4 formulary drugs listed. Your Formulary book is an abridged version that does not list all strengths or multiple names of the drug. Most covered Medicare Part D drugs are on your formulary. Since a formulary can change at any time, if there is any question about drug coverage, you must call Customer Service for clarification at 1-877-968-3550.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your copayment depends on which drug tier your drug is in. The table below shows the copayment and/or coinsurance amount you pay for each tier when you are in your initial coverage limit and when you obtain your prescription from the Depot Drug Mail Pharmacy, or a retail network or specialty drug pharmacy. As you can see, your benefits are stretched through lower copayments when you obtain your prescriptions from the Depot Drug Mail Pharmacy.

2024 Copayment chart for drug tiers

2024 Copayment Amounts for Part D Drugs	Tier 1 Generic Drugs 30-Day	Tier 2 Brand Preferred 30-Day	Tier 3 Brand Non-Preferred 30-Day	Tier 4 Specialty Drugs 30-Day
Depot Drug Mail Pharmacy $$$ Your Best Money Saver Tier 1 Generic drugs 90-day supplies only. Tiers 2 & 3 drugs may be 30, 60, or 90-day supplies.	$3 ($9 for 90-day	$15	Higher of $75 or 33% of drug cost	Not Supplied
National Retail Pharmacy Network Includes Specialty Pharmacies 30, 60 or 90-day supplies	$15	$30	Higher of $90 or 33% of drug cost	33% of drug cost 30-day or less supply only
Note: Out-of-Network Pharmacy - Emergency Only We refund you the SFEHACL cost for the Part D drug minus your Retail tier copayment amount. You pay any charges above our cost. If you are in the Coverage gap and the generic and brand name discounts were not applied from the pharmacy, you will not be reimbursed for the discount amounts. Non-Part D drugs are not covered. *If the actual cost-plus dispensing fee for a prescription is less than the Tier copayment amount for that drug, you will pay the actual cost-plus dispensing fee, not the copayment! Some drugs would cost you less under this rule so make sure that you use your SFEHACL ID card!				

Sometimes you can get less than a full month's supply

Depot Drug Mail Pharmacy does not supply a partial fill for a drug normally taken daily. You will need to get those from retail network pharmacies.

Usually you pay a copay to cover a full month's supply of a covered drug, or for a full prescription that is less than 30 days (like an antibiotic). For drugs that would normally be taken daily, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug that is new for you (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees, you will not have to pay for the full month's supply for certain drugs on a new prescription.

The amount you pay when you get less than a full month's supply for a new drug that is normally taken daily will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a set amount depending on tier placement).

- Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.
- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the *daily cost-sharing rate*) and multiply it by the number of days of the drug you receive.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.
- You should not have to pay more per day just because you begin with less than a month's supply. Let's go back to the example above. Let's say you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7 days' supply runs out. If you receive a second prescription for the rest of the month, or 23 days more of the drug, you will still pay $1 per day, or $23. Your total cost for the month will be $7 for your first prescription and $23 for your second prescription, for a total of $30 – the same as your copay would be for a full month's supply.

Can the formulary change?

We and/or Medicare may add or remove drugs from the formulary during the year. If the drug is covered by Medicare, it will be covered by SFEHACL. Drug manufacturers constantly change, discontinue and/or add new drugs. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, add prior authorizations, quantity limits, any other restrictions, or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you up to a 60-day supply (depending on the number of refills left on your prescription) of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, or the manufacturer stops making the drug, we will not give 60 days' notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

What if your drug is not on the formulary?

Most Part D drugs are on the SFEHACL formulary. If Medicare Part D covers your drug, it is usually included in our formulary. You can contact Customer Service at 1-877-968-3550 to be sure if a drug is covered. If Customer Service confirms that Medicare Part D does not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by Medicare. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please show him/her your Formulary book.
- You can ask us to make an exception to cover your drug **only** if it is a Medicare-covered Part D drug, and all of those are already on our plan formulary.
- You can pay out-of-pocket for the drug and request that our plan reimburse you by requesting a formulary exception if the drug is covered by Medicare Part D. Since Most Part D drugs are on the SFEHACL formulary, this would rarely apply. This does not obligate our plan to reimburse you if the exception request is not approved. See Section 5 for more information on how to request an appeal.

If there are extra rules that apply to the drug you take

Some of the drugs covered by SFEHACL have extra rules to restrict their use. In most instances, the rules applied are required by Medicare, Federal, or state. Some drugs are limited in the number of pills covered during a particular time period because of safety rules applied to that drug. If your drug restricted, here are things you can do:

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

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

Temporary (or transition) drug supplies

The intent of providing a temporary (transition) supply of a Medicare Part D drug that has restrictions applied to it is to allow your physician time to provide SFEHACL with the necessary information to make a coverage determination.

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

Under certain circumstances, SFEHACL can offer a temporary supply of a Part D drug to you when your drug is restricted in some way. Remember that all Part D covered drugs are on the SFEHACL Formulary so this process would only apply to drugs that have restrictions. Giving you a temporary supply gives you time to talk with your provider about the restriction and figure out what to do. To receive a temporary supply, you must be in one of the situations described below.

If there are restrictions on your Part D drug:

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

  We will cover a temporary supply of your Part D drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of 30 days at a time, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy. This will give you time to have your physician provide the necessary information to determine if the restrictions apply to your drug.

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

  We will cover a temporary supply of your Part D drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 30-day supply at a time, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy. This will give you time to have your physician provide the necessary information to determine if the restrictions apply to your drug

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

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 91 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

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

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

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

What types of drugs does Medicare or SFEHACL not cover?

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

- Non-prescription drugs (also called over the counter, or OTC drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring service be purchased exclusively from the manufacturer as a condition of sale
- A Medicare Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B.

Our plan usually cannot cover off-label use. *Off-label use* is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Congress specifically lists the reference books that are used. If the use is not supported by one of these references (known as compendia), then the drug is a non-Part D drug and is not covered by Medicare or our plan.

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

There are restrictions on coverage for some drugs

For certain prescription drugs, we have additional requirements or limits for 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. In most cases, Medicare developed these requirements and limits for our plan to provide quality coverage to our members. Examples of utilization management tools are described below:

- **Prior Authorization**: You must get prior authorization for certain drugs that Medicare has determined that are only covered under certain circumstances. This means that you, your representative, or your doctor will need to get approval from us before you fill your prescription. If you don't get approval, we may not cover the drug. Medicare requires all plans to prior authorize certain Part D drugs and all SFEHACL members will require those prior authorizations.
- **B/D Drugs Prior Authorization**: You must get prior authorization for certain drugs that Medicare has determined are only covered under Part D in certain circumstances and by Part B

in other circumstances. You, your representative, or your doctor need to get approval from us before you fill your prescription. If you don't get approval, we may not cover the drug. Medicare requires all plans to prior authorize certain Part D drugs and all SFEHACL members will require those prior authorizations.

- **Quantity Limits**: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. These limitations are usually placed because of Federal and/or state regulatory safety requirements.
- **Step Therapy**: In some cases, SFEHACL 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, SFEHACL may not cover drug B unless you try Drug A first. If Drug A does not work for you, SFEHACL will then cover Drug B.
- **Generic Substitution**: When there is a generic version of a name brand drug available, we will automatically give you the generic version. Brand name drugs with generic versions are usually found in a higher tier copayment on our formulary. If your doctor tells you that you must take the brand name drug, it is still available to you, but at a higher copayment.

You can find out if your drug is subject to these additional requirements or limits by looking in the Formulary Book under the BI (Benefit Indicator) column. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. For more information, see *How do I request an exception to the formulary?*

Programs on drug safety

We conduct drug reviews for all of our members to make sure that you are receiving safe and appropriate care. These reviews are particularly important for members who have more than one doctor who prescribe their medications. We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

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

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

Medication Therapy Management Program to help members manage their medications

We have a program called Medication Therapy Management (MTM) that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, and they could have very high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

Some members who take several medications for different medical conditions may qualify. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, or any problems you're having. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

We will automatically enroll you in the program and send you information if you fit our requirements. If you decide not to participate, we will give you instructions on how to notify us and we will withdraw your participation in the program.

Does your enrollment in our Plan affect the drugs covered under Medicare Part A or Part B?

Your enrollment in our plan does not affect Medicare Part A or Part B drug coverage. If you are admitted to a hospital for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this Section that tell about the rules for getting drug coverage.

If you are admitted to a skilled nursing facility for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this Section that tell about the rules for getting drug coverage.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Section 6 tells when you can leave our plan and join a different Medicare plan.) See your Medicare & You book for more information about drugs that are covered by Medicare Part A and Part B.

How much do you pay for drugs covered by our Plan in the different benefit levels?

If you qualify for *Extra Help* with your drug costs, your costs may be different than those described below. See the Introduction Section of this book under *Medicare's Extra Help Program* more information.

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage limit, out-of-pocket stage after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at the Depot Drug Mail Pharmacy, a retail network pharmacy, or an out of network pharmacy. Your drug costs for each coverage level are described below.

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

Deductible

On your behalf, SFEHACL pays your 2024 annual deductible which is determined each year by CMS. This is the amount that must be paid each year before Medicare will begin paying for part of your drug costs. After SFEHACL pays the deductible for you, you will continue to have benefits available until you reach the initial coverage limit of your benefits. Even though SFEHACL pays our deductible, during the deductible period, your copayments apply to your out-of-pocket expenses for Medicare Part D covered drugs. See your Summary of Benefits.

Initial Coverage Benefit Stage

During the initial coverage benefit stage, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. Every drug on our Formulary List is in one of four cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug. The amount you pay when you fill a covered prescription is called the copayment, or for some drugs it will be coinsurance. Your copayment will vary depending on the drug and where the prescription is filled.

Once your total drug costs reach $5,030 you will have reached the end of your initial coverage benefit stage. Your initial coverage limit is calculated by adding payments made by our plan and you. If other individuals, organizations, and another insurance plan or policy help pay for your drugs under our plan, the amount they spend may count towards your initial coverage limit.

Out-of-pocket Stage (Coverage Gap) before you qualify for Catastrophic Coverage

During the coverage gap stage, you receive a 75% discount on brand name drugs and a 75% discount on the costs of generic drugs. The Medicare Coverage Gap Discount Program will provide manufacturer discounts on most brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving *Extra Help*. Drug manufactures of brand name drugs that have agreed to the discount reduce the cost of the drug by 70% on the negotiated price (excluding the dispensing fee) and the other 5% is paid by SFEHACL to equal the 75 % discount to you. You get credit towards your out-of-pocket amount for the 95% portion of this discount. You do not get credit for the 5% paid by SFEHACL.

We will automatically apply the discount at the Depot Drug Mail Pharmacy and retail network pharmacies when your prescriptions are filled. This information will also be displayed when you request an Explanation of Benefits from SFEHACL. If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone number is on the front cover).

After your total drug costs under your initial coverage limit reach $5,030, you, or others on your behalf, will pay 100% (less the brand and generic discounts) for your drugs until your total out-of-pocket costs reach $8,000 and then you will qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $8,000 out-of-pocket for the year. When the total amount you have paid in copayments and out-of-pocket costs for covered Medicare Part D drugs reaches $8,000, you will qualify for catastrophic coverage, there would be not be a copay for the member after reaching the max out of pocket. Once you are in the catastrophic coverage stage, you will stay in this stage for the rest of the year.

How is your out-of-pocket cost calculated?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug is normally covered by Medicare Part D, is on our plan formulary, and it was obtained through the Depot Drug Mail Pharmacy or at a retail network pharmacy, or you have an approved emergency claim from an out of network pharmacy:

- Your copayments and;
- Payments you make after your initial coverage limit.

When you have spent a total of $8,000 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level. Purchases that will **not** count toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories.
- Prescription drugs not covered by our Plan and Medicare Part D.

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 Medicare 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 prescription drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAP's) or an AIDS Drug Assistance Program (ADAP);
- Medicare programs that provide Extra Help with prescription drug coverage; and/or
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

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

- Group Health Plans;
- Insurance Plans and government funded health programs (Veterans, TRICARE the Indian Health Service, etc.); and
- Third party arrangements with a legal obligation to pay for prescription costs (Workers Compensation, accident insurance, etc.).

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 cost amount. If you or another party on your behalf has purchased drugs outside of our Plan, you will be responsible for submitting appropriate documentation of such purchases to us.

Explanation of Benefits

An Explanation of Benefits (EOB) is a document that details our current record of all of your prescription benefits provided to you up to the day of your request. The EOB is subject to change at any moment and may not reflect your current benefit accurately if you have obtained any prescriptions from a retail network pharmacy, an out of network pharmacy, a LTC pharmacy has not submitted their claims, or received vaccine from your physician. You may request an EOB at any time by calling our Customer Service at 1-877-968-3550.

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

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, our plan will cover your prescriptions as long as they are not covered by Medicare Part A or B, they are a covered Part D drug, and the facility's Long-Term Care Pharmacy is in our retail network. 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 our Plan and join a new Medicare Prescription Drug Plan.

SECTION 4 Making Complaints

If your problem is about decisions related to benefits, coverage, or payment, then this Section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5.

This Section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, the customer service you receive, or Medicare rules.

Legal Terms

- What this Section calls a complaint is also called a grievance.
- Another term for making a complaint is filing a grievance.
- Another way to say *using the process for complaints* is *using the process for filing a grievance*.

Problems that are handled by the complaint process

The complaint process is used for certain types of problems ONLY. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can make a complaint. Call Customer Service at 1-877-968-3550 if you have a complaint.

- Quality of your medical care
  - Are you unhappy with the quality of the care you have received?
- Respecting your privacy
  - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- Disrespect, poor customer service, or other negative behaviors
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Customer Service has dealt with you?
  - Do you feel you are being encouraged to leave our plan?
- Waiting times
  - Have pharmacists kept you waiting too long? Have our Customer Service or other staff at our plan kept you waiting too long?
  - Examples include waiting too long on the phone or when getting a prescription.
- Cleanliness
  - Are you unhappy with the cleanliness or condition of a pharmacy?
- Information that you get from our plan
  - Do you believe we have not given you information that we are required to give?
  - Do you think written information we have given you is hard to understand?

Complaints related to the timeliness of our actions on coverage decisions and appeals

The process of asking for a coverage decision and making an appeal is explained in Section 5 of this book. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a fast coverage decision or appeal and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Step-by-step process for making a complaint

The following pages give you instructions on how to make complaints.

Step 1 for making complaints

Contact us promptly – either by phone or in writing

- Usually, calling Customer Service is the first step. If there is anything else you need to do, Customer Service will let you know. We can usually resolve any complaint or problem you may have on the telephone.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- Whether you call or write, you should contact Customer Service right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint. If you have a fast complaint, it means we will give you an answer within 24 hours.

Legal Term

- What this Section calls a *fast complaint* is also called an *expedited grievance*.

Step 2 for making complaints

SFEHACL looks into your complaint and gives you an answer.

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- Sometimes we will ask if we can call you back after we find out more facts about your complaint. Return calls are usually made the same day but can be within 5 business days.
- Most complaints are answered quickly. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 30 days and 14 more days (44 days total) to answer your complaint.
- If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

You may complain about the quality of care received under Medicare. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO) in your state, or both. If you file with the QIO, we must help them resolve the complaint. See the Important Numbers and Resources Section of this book for help to find the QIO in your state.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, addresses, and phone number of the Quality Improvement Organization for your state, look in the Important Phone Numbers and Resources Section of this book. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.
- You can also tell Medicare about your complaint
    - You can submit a complaint about SFEHACL directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.
    - If you have any other feedback or concerns, or if you feel SFEHACL is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Section 5 What to do if you have a Problem and Need a Coverage Decision, or Appeal

Introduction

This Section explains another type of process for handling problems and concerns. For some types of problems, you need to use the process for coverage decisions and making appeals. For other types of problems, you need to use the process for making complaints explained in Section 4.

Is your problem or concern about your benefits or coverage?

- No. Go to Section 4 which explains how to make a complaint (file a grievance).
- Yes. Go on to the instructions in this Section.

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

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

Legal Terms

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

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

An initial coverage decision about your Part D drugs is called a coverage determination. Asking for removal of a restriction on coverage for a drug is sometimes called asking for a formulary exception. A fast decision is called an expedited coverage determination. A fast appeal is also called an expedited redetermination. An appeal to the plan about a Part D drug coverage decision is called a plan redetermination.

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

GET HELP FROM AN INDEPENDENT GOVERNMENT ORGANIZATION NOT CONNECTED TO SFEHACL

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected us. You can always contact your State Health Insurance Assistance Program (SHIP). This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do. The services of SHIP counselors are free. To find the SHIP in your state call Medicare at (1-800-633-4227), 24 hours a day, 7 days a week and ask them to help you find the SHIP in your state or go to www.medicare.gov.

YOU CAN GET HELP AND INFORMATION FROM MEDICARE

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

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

What is an exception (coverage decision)?

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

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

- You cannot ask for an exception for coverage of any excluded drugs or other non-Part D drugs which Medicare does not cover.
- Asking us to remove a restriction on our coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on our Formulary list. We impose those restrictions required by Medicare, state or Federal regulations, and certain safety restrictions.
    - Prior Authorization or PA B/D (PA). Getting plan approval in advance before we will agree to cover the drug for you. This is sometimes called prior authorization (PA). Some prior authorizations are required to determine if coverage should be under Part B or Part D. We impose PA restrictions required by Medicare, and certain safety restrictions.
    - Quantity Limits (QL). For some drugs including those with state and Federal restrictions, SFEHACL limits the amount of the drug you can have during a given period of time.
- Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Formulary is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
    - If your drug is in Tier 3, you can ask us to cover it at the cost-sharing amount that applies to Tier 2. However, before you ask for an exception, please ask Customer Service to tell you which alternative drugs are on our less expensive Tiers 1 or 2.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

Important things to know about asking for exceptions (coverage decisions)

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

Typically, our Formulary includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we would advise you to take the alternative drug first.

WE CAN SAY YES OR NO TO YOUR REQUEST

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

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

Step-by-Step instructions to ask for a coverage decision or an exception

The following information gives you step-by-step instructions on how to ask for a coverage decision and/or an exception.

Step 1 for Coverage Decisions and Exceptions

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

- Request the type of coverage decision you want. Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. Or if you are asking us to pay you back for a drug, go to Section 1 How do I submit a request for payment?
- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision or a Level 1 or 2 appeal. This Section told how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- If you want to ask us to pay you back for a drug, start by reading Section 1 of this booklet. It describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are requesting an exception, provide the doctor's statement. Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the doctor's statement.) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.
- We must accept any written request, including a request submitted on the Coverage Determination Request Form available on our website.
- If your health requires it, ask us to give you a fast decision.
- When we give you our decision, we will use the standard deadlines unless we have agreed to use the fast deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- To get a fast decision, you must meet two requirements:
    - You can get a fast decision only if you are asking for a drug you have not yet received. (You cannot get a fast decision if you are asking us to pay you back for a drug you have already bought.)
    - You can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- If your doctor or other prescriber tells us that your health requires a fast decision, we will automatically agree to give you a fast decision.
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast decision.
    - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
    - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a fast complaint, which means you would get our answer to your complaint within 24 hours.

Step 2 for Coverage Decisions and Exceptions

We consider your request and we give you our answer.

Deadlines for a fast coverage decision:

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

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

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

- If we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

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

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

Step 3 for Coverage Decisions and Exceptions

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

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

Making an appeal

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

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

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

Step-by-Step instructions to make an Appeal

The following information gives you instructions on how to make an appeal (how to ask for a review of a coverage decision made by our plan).

Step 1 to make a Level 1 Appeal

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

What to do:

- To start your appeal, you, your doctor, or your representative, must contact us.

- Details on how to reach us by phone, fax, or mail for any purpose related to your appeal are on the cover of this booklet.

- If you are asking for a standard appeal, make your appeal by submitting a written request.
- If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown on the cover of this booklet.
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our Web site.
- You can ask for a copy of the information in your appeal and add more information.
    - You have the right to ask us for a copy of the information regarding your appeal.
    - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

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

Step 2 to make a Level 1 Appeal

We consider your appeal and we give you our answer.

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

Deadlines for a fast appeal

- If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this Section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)
- If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a standard appeal

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

Step 3 to make a Level 1 Appeal

If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Step-by-step instructions to make a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Organization reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Step 1 to make a Level 2 Appeal

To make a Level 2 Appeal, you or your representative, your doctor, or other prescriber must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include instructions on how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your case file. You have the right to ask us for a copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2 to make a Level 2 Appeal

The Independent Review Organization does a review of your appeal and gives you an answer.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for fast appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal.
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request.
- If the Independent Review Organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.

Deadlines for standard appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal.
- If the Independent Review Organization says yes to part or all of what you requested
    - If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization.
    - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called upholding the decision. It is also called turning down your appeal.)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3 to make a Level 2 Appeal

If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge. The following pages tell more about Levels 3, 4, and 5 of the appeals process.

Taking your appeal to Level 3 and beyond

The following information tells you about Levels of appeals 3, 4, and 5 for Part D Drugs. This information may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal

A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an Administrative Law Judge (ALJ).

- If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Administrative Law Judge within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- If the Administrative Law Judge says no to your appeal, the appeals process may or may not be over.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal

The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Medicare Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- If the answer is no, the appeals process may or may not be over.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.
- You will be informed after Level 4 how to go to Level 5.

Section 6 Ending your Membership in the SFEHACL Medicare Plans

When can you end your membership in SFEHACL?

If you do not want to end your membership, do nothing. SFEHACL will automatically reenroll you for the coming year. You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave during the Annual Enrollment Period. In certain situations, you may also be eligible to leave at other times of the year.

You can end your membership from our plan during the Annual Enrollment Period from October 15 through December 7. In certain cases, you can leave at other times of the year such as if you enter a nursing home. After you request to leave, we will let you know in writing the date your coverage ends. If you do not get a letter, call Customer Service and ask for the date.

What is disenrollment?

All SFEHACL Medicare members are enrolled in all SFEHACL Medicare Plans. These plans include the SFEHACL HCPP & Medicare Secondary Plan and the Medicare Part D Plan. You are automatically enrolled in the SFEHACL Medicare Part D plan each year. If you choose to disenroll from SFEHACL, you will also lose your SFEHACL HCPP & Medicare Secondary Plan.

*Disenrollmen*t from our plan means ending your membership with us. Disenrollment can be voluntary (your own choice) or, in limited circumstances, involuntary (not your own choice).

You might leave our plan because you have decided that you *want* to leave. You can decide to leave for any reason during specified times. There are also a few situations where you would be *required* to leave. For example, you will have to leave our plan if we no longer offer prescription drug coverage in your geographic area. We are not allowed to ask you to leave our plan because of your health.

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

Usually, you can end your membership during the Annual Enrollment Period

You can end your membership during the Annual Enrollment Period (also known as the *Annual Coordinated Election Period*) from October 15 through December 7 each year. This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

You are automatically enrolled in the SFEHACL Medicare Part D plan each year. Being a Medicare member of SFEHACL, you are enrolled under all Medicare plans. If you choose to disenroll from our Part D plan during the Annual Coordinated Enrollment Period, you will also lose your SFEHACL HCPP & Medicare Secondary Plan membership.

- When is the Annual Enrollment Period? It is October 15 to December 7.
- What type of plan can you switch to during the Annual Enrollment Period? During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare prescription drug plan.
- Original Medicare *without* a separate Medicare prescription drug plan.
- A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.

- If you enroll in another Medicare health plan, you will be disenrolled from the SFEHACL Medicare plans when your new plan's coverage begins. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.
  - **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (*Creditable coverage* means the coverage is at least as good as Medicare's standard prescription drug coverage.)
- When will your membership end? Your membership will end when your new plan's coverage begins on January 1.

In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of SFEHACL may be eligible to end their membership at other times of the year. This is known as a Special Enrollment Period. In order to qualify for a Special Enrollment Period, one of the following must apply to you:

- Who is eligible for a Special Enrollment Period? If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can call Medicare, or visit the Medicare website (http://www.medicare.gov):
  - If you have Medicaid.
  - If you are eligible for *Extra Help* with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care hospital.
- When are Special Enrollment Periods? The enrollment periods vary depending on your situation.
- What can you do? Remember, you cannot maintain your membership in the SFEHACL HCPP and Medicare Secondary Plan without being enrolled in the SFEHACL Medicare Part D plan too. To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
  - A Medicare managed care health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage plans also include Part D prescription drug coverage.

- If you receive *Extra Help* from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- As a SFEHACL HCPP & Medicare Secondary Plan member, you are automatically enrolled in the SFEHACL Part D Medicare prescription drug plan each year.
- When will your membership in SFEHACL end? Your membership will usually end on the first day of the month after we receive your request to change your plan.
- If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (*Creditable coverage* means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

To get more information about when you can end your membership

- You can call Customer Service at 1-877-968-3550.
- You can find the information in the Medicare & You book. Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy from the Medicare website at www.medicare.gov. Or, you can order a printed copy by calling Medicare at the number below.
- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How do you end your membership in SFEHACL?

You have all SFEHACL Medicare Plans. If you disenroll in the Medicare Part D plan, you cannot maintain your membership in the SFEHACL HCPP and Medicare Secondary Plan.

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods. However, there are two situations in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will end your membership with SFEHACL. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop your Medicare prescription drug coverage.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request to us in writing. Contact Customer Service to find out how to do this.
- You can contact Medicare at 1-800 Medicare (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You must keep getting your prescriptions through our plan until your membership ends

Remember if you disenroll from our plan, you also disenroll from the SFEHACL Medicare HCPP & Medicare Secondary Plan, and you may not get another opportunity to enroll again.

If you leave, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your prescription drugs through our plan. You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy. Prescription drugs are only covered if they are filled according to the plan rules in this booklet.

SFEHACL must end your membership in our Medicare plans under certain situations

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance, you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
    - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan.
    - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs.
    - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.
- If you do not pay the plan premiums. See Section 2.
    - If you do not pay the plan premiums, you have a 2-month grace period during which you can pay before you are disenrolled for failure to pay the plan premium.

If you move out of our plan's service area

SFEHACL Part D Medicare Plan is a national plan. If you move permanently outside of the United States, please call our Customer Service at 1-877-968-3550. If you move permanently out of the United States, you will need to leave (disenroll from) our plan. An earlier part of this Section tells about the choices you have if you leave our plan and explains how to leave.

We cannot ask you to leave our plan because of your health

No member of any Medicare Prescription Drug Plan can be asked to leave any plan for any health-related reasons or the number of prescriptions a member takes. If you ever feel that you are being encouraged or asked to leave our plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048), the national Medicare help line.

You have the right to make a complaint if we ask you to leave our plan

If we ask you to leave our plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 4 and 5 for more information.

Section 7 Your Rights, Responsibilities and Protections

About your rights, responsibilities and protections

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

Your right to be treated with fairness and respect

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

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

If you have a disability and need help with access to care, please call our Customer Service at 1-877-968-3550. If you have a complaint such as a problem with wheelchair access, we can help.

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

As a member of SFEHACL, you have the right to get your prescriptions filled or refilled without long delays. As explained in this Benefit Guide, you should get all of your maintenance (drugs taken longer than 30 days) prescriptions filled from the preferred cost-sharing Depot Drug Mail Pharmacy. If you think you are not getting your Part D drugs within a reasonable amount of time, you can call our Customer Service for personal help. Section 1 explains how to use the preferred cost-sharing Depot Drug Mail Pharmacy, or a standard cost-sharing retail network pharmacy to get a prescription filled.

We must protect the privacy of your personal health information

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

- Your *personal health information* includes the personal information you give us when you enroll, your medical record information and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. Upon request, we provide a written notice called a Notice of Privacy Practice that tells about these rights and explains how we protect the privacy of your personal information.

HOW DO WE PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written

permission can be given by you or by someone that you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of SFEHACL through Medicare, we are required to give them your health information and information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this is done according to Federal statutes and regulations.

YOU CAN SEE THE INFORMATION IN YOUR RECORDS AND KNOW HOW IT HAS BEEN SHARED WITH OTHERS.

You have the right to look at your medical records and to get a copy of your records. SFEHACL is usually not in possession of your medical records – those are at your health care provider's site. The provider is allowed to charge you a fee for making copies of your records. You have the right to ask your provider to make additions or corrections to your medical records.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service at 1-877-968-3550.

Your right to get information about our plan, pharmacies and your covered drugs

As a member of SFEHACL, you have the right to get several kinds of information from us. If you want any of the following kinds of information, please call Customer Service at 1-877-968-3550:

- Information about our plan. This includes information about our financial condition. It also includes information about the number of appeals made by members of our plan.
- Information about our network pharmacies. For more detailed information about use of the Depot Drug Mail Pharmacy and retail network pharmacies, see Section 1 of this booklet.
- Information about your coverage and rules you must follow in using your coverage. To get the details on your Part D coverage, read this booklet. If you have questions about the rules or restrictions, please call Customer Service at 1-877-968-3550.
- Information about why something is not covered and what you can do about it.
    - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
    - If you are not happy, or if you disagree with a decision, we make about what Part D drug is covered for you, you have the right to ask us to change the decision by making an appeal. See Section 5 for details on how to make an appeal.
    - If you want us to pay our share of the cost for a Part D prescription drug and you did not use a participating pharmacy, see Section 1 on how to submit a paper claim.

We must support your right to make decisions about your care

You have the right to give instruction about what is to be done if you are not able to make medical decisions for yourself. Sometimes people become unable to make health care decision for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that *if you want to,* you can:

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

The legal documents that you can use to give your directions in advance in these situations are called *advance directives*. There are different types of advance directives and different names for them. Documents called *living will* and *power of attorney for health care* are examples of advance directives. If you want to use an advance directive to give your instructions, here is what to do:

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

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

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

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

What if your instructions are not followed? If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with your state Department of Health.

Your right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered service or care, Section 4 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Section 4 and 5, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service at 1-877-968-3550.

What can you do if you think you are being treated unfairly or your rights are not being respected?

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

Is it about something else?

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

- You can call Customer Service at 1-877-968-3550.
- You can call your State Health Insurance Assistance Program.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights

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

- You can call Customer Service at 1-877-968-3550.
- You can call the State Health Insurance Assistance Program mentioned in the Important Phone Numbers and Resources Section of this book.
- You can contact Medicare.
    - You can visit the Medicare website to read or download the publication *Your Medicare Rights & Protections.* The publication is available at www.medicare.gov/Publications.
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have some responsibilities as a member of the SFEHACL Medicare Plans

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

- Become familiar with your covered drugs and the rules you must follow to get these covered drugs. Use this Benefit Guide (EOC) and all the Medicare material we send to you to learn what is covered for you and the rules you need to follow to get your covered drugs.
    - Sections 1 and 3 give the details about your coverage for Part D prescription drugs.

- If you have any other prescription drug coverage in addition to our plan, you are required to tell us. Please call Customer Service to let us know.
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called *coordination of benefits* because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it.
- Tell your doctor and pharmacist that you are enrolled in our plan. Show your plan membership ID card whenever you get your Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- Pay what you owe. As a plan member, you are responsible for these payments:
    - Pay your SFEHACL premiums and pay your Medicare Part B premium.
    - For some of your drugs covered by us, you must pay your share of the cost when you get the drug. This will be a copayment. Sections 1, 2 and 3 tell what you must pay for your Part D prescription drugs.
    - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of SFEHACL.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member or our plan.
- Tell us if you move. If you are going to move, it's important to tell us right away. Call Customer Service at1-877-968-3550.
- Call Customer Service at 1-877-968-3550 for help if you have questions or concerns, problems, or suggestions. We also welcome any suggestions you may have for improving our plan. Phone numbers and calling hours are also on the front and back cover of this book.

Section 8 Legal Notices

Notice about governing law

Many laws apply to this Benefit Guide 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 Service, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, and plans like SFEHACL plans, 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, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR Sections 422.108 and 423.462, SFEHACL, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this Section supersede any state laws.

Information required by the Employee Retirement Income Security Act of 1974 ("ERISA")

As a Member in the Santa Fe Employes Hospital Association Coast Lines Medicare Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the SFEHACL office all documents governing the Plan, including a copy of the latest annual report filed by our Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of documents governing the operation of the Plan including collective bargaining agreements and copies of the latest annual report and updated summary plan description upon written request to our Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of our Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duty upon the people who are responsible for the operation of the employee benefit plan. The people who operate SFEHACL are called "Fiduciaries" of the Plan. They have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request copies of Plan documents or the latest annual report and do not receive them within thirty days, you may file suit

in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. To ensure your request was not lost in the mail, you should call the Plan Administrator first. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees: for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20240, telephone 866-444-3272 (toll free). You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications line of the Employee Benefits Security Administration at 202-693-8673 (this is a toll line).

Name of Plan	Santa Fe Employes Hospital Association- Coast Lines (the "Plan")	
Plan Sponsor	Santa Fe Employes Hospital Association – Coast Lines	
Plan Identification Numbers	Employee Identification Number (EIN): 95-1191130 CMS HCPP Plan Number (PN): H6053; CMS EGWP Plan Number: S8841	
Plan Administrator	Santa Fe Employes Hospital Association- Coast Lines 551 East San Bernardino Road Covina, CA 91723 Telephone: 877-968-3550 Fax: 626-967-3161	
Type of Plan	Health Care Benefit Plan; Medicare HCPP; Medicare Prescription Drug Plan administered by OptumRx	
Trustee	Wells Fargo Bank, N. A. 5 Park Plaza, 20th Floor Irvine, CA 92614	
Current Board of Trustees of Plan	Larry D Philippi, Chairman David M. Bocanegra, Vice-Chairman Stephen T. Dawson, Secretary/Treasurer Greg Luiz, Member Daniel Lee O'Connell, Member	Tommy G. Pate, Member
Operating Trustees	Larry D. Philippi, Chairman Stephen T. Dawson, Secretary/Treasurer	
Agent for Service of Legal Process	Service of Legal Process may be made upon the Plan Administrator or any Trustee listed above.	
Type of Administration of Health Care Benefits Provided by the Plan & Plan Year	Trustees and Self-Administered. The Plan is administered directly by the Plan Administrator. The Plan's healthcare benefits are funded directly by the Plan and are not insured by an outside entity. Each Plan Year ends each year on December 31.	

Section 9 Definitions of Important Words Used in This Benefit Guide (Evidence of Coverage)

For the terms listed below, this Section either gives a definition or directs you to a place in this Benefit Guide that explains the term.

Annual Enrollment Period –A set time each fall when members can change their health or drug plans. The Annual Enrollment Period (AEP) is from October 15 until December 7. You can only join a new Medicare health or drug plan during the AEP.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received Remember that SFEHACL includes Most Part D drugs on our formulary. Section 5 explains what appeals are, including the process involved in making an appeal.

Benefit Guide (Evidence of Coverage) and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your coverage, defines our obligations, and explains your rights and responsibilities as a member of our plan.

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

Catastrophic Coverage Level – This is the benefit stage in the Part D Drug program where you pay a low co-payment or coinsurance for your drugs. This occurs after you or other qualified parties on your behalf have spent the annual required out-of-pocket amount in covered drugs during the covered year.

Centers for Medicare & Medicaid Service (CMS) – This is the Federal agency that runs the Medicare program. The Introduction tells you how you can contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for Medicare Part D prescription drugs. Coinsurance is a percentage of the cost as in some Tier 3 and Tier 4 formulary drugs.

Copayment – An amount you may be required to pay as your share of the cost for a Medicare Part D prescription drug. A copayment is a set amount as in Tier 1 and Tier 2 drugs, rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. This is in addition to the monthly premium. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered. SFEHACL pays your annual deductible amount so this does not apply to you; (2) any fixed copayment amounts that a plan may require be paid when specific drugs are received; or (3) any coinsurance amount that must be paid as a percentage of the total amount paid for a drug.

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

Covered Drugs – The term we use to mean all the prescription drugs covered by us and Medicare Part D. SFEHACL includes most Part D drugs in your formulary.

Creditable Prescription Drug Coverage – This is prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty when they enroll in Medicare Part D later.

Customer Service – This is a department within SFEHACL responsible for answering your questions about your membership, benefits, grievances, and appeals. See the Introduction for information about how to contact SFEHACL or call Customer Service at 1-877-968-3550.

Daily Cost-Sharing Rate – A *daily cost-sharing rate* may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A *daily cost-sharing rate* is the copay divided by the number of days in a month's supply. Example: If your copay for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, they your daily cost-sharing rate is $1 per day. This means you pay $1 for each day's supply when you fill your prescription

Deductible – The amount of money that Medicare requires you to pay for your drugs first, before the plan will begin paying for your covered drugs. SFEHACL pays your annual deductible for you.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription, and the postage costs if a mail order drug.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug at a less costly Tier (a tiering exception), have an exception to prior authorization rules, or you may also request an exception if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Formulary – A list of covered Medicare Part D drugs provided by our plan. SFEHACL Part D Medicare Plan includes most Medicare Part D covered drugs on our formulary.

Generic Drug – These are prescription drugs that are approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about us, Medicare, one of our network pharmacies, and including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. Single and married couples with the higher income must pay a higher Medicare Part B and Medicare Part D prescription drug coverage premium amount. The additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected.

Initial Coverage Limit – The maximum limit of coverage under the Part D Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug expenses have reached $4,130 including amounts you've paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period when you can sign up for Medicare Part A and B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without creditable prescription drug coverage.

List of Covered Drugs (Formulary or Drug List) – A formulary is a list of prescription drugs covered by SFEHACL. The SFEHACL Formulary includes most brand name and generic Medicare Part D drugs.

Low Income Subsidy – See Extra Help

Medicaid (or Medical Assistance) - A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – This is the use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medicare – This is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. SFEHACL is not an MA plan. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a MA plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most

cases, MA plans also offer Medicare Part D. These plans are called Medicare Advantage Plans with Prescription Drug Coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program - A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving Extra Help. Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, Medicare Part D brand name drugs are discounted.

Medicare Covered Services – Services covered by Medicare Part A and Part B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

Medigap Policy – Medicare supplement insurance sold by private insurance companies to fill gaps in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plans. (A Medicare Advantage plan is not a Medigap policy.) **The SFEHACL Medicare Secondary Plan is NOT a Medigap Policy because we are not-for-profit and only certain people can join our plan.**

Member (member of our plan) – A person with Medicare who is eligible for SFEHACL and enrolled in Medicare Parts A and B, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Service (CMS).

Retail Network Pharmacy – A retail pharmacy that offers covered drugs to members of our plan.

Original Medicare – (Traditional Medicare or Fee-for-service Medicare) Original Medicare is offered by the government and not a private health plan like MA plans and prescription drug plans. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers' payment amounts established by Congress. All SFEHACL Medicare members are covered under Original Medicare. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible and your share (the SFEHACL Medicare Secondary Plan pays most of these amounts). Medicare pays its share of the Medicare-approved amount and SFEHACL pays your share (some exceptions and out-of-network reductions apply). Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out of Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered Part D drugs to SFEHACL members. As explained in this Benefit Guide, most of the prescriptions you get from out of network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for *cost sharing* above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's out-of-pocket costs.

Part C – see Medicare Advantage (MA) Plan.

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

Part D Drugs – Drugs that can be covered under Part D. SFEHACL includes most Part D drugs in our formulary. See your formulary for a specific list. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Premium – The monthly or quarterly payment to SFEHACL in payment for your Part D plan and your Medicare Secondary Plan coverage. You must also make payment to Medicare for your Part B coverage.

Prior Authorization (or Preauthorization, PA) – This is approval in advance to get certain drugs that may or may not be covered by us. Medicare requires us to preauthorize certain drugs that may be covered under Part B or Part D, or only covered if you have certain conditions. These drugs are covered only if your doctor or other plan provider gives us your information. Covered drugs that need prior authorization are marked with a PA, or BD in the formulary book.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare providers.

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 Medicare within which an eligible individual may enroll in a plan. The SFEHACL Medicare Plans are national.

Special Enrollment Period – A set time when you can change health or drug plans or return to Original Medicare. Situations for a Special Enrollment Period include: if you are getting *Extra Help* with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Specialty Drug Pharmacy – A pharmacy that provides high cost medications that treat conditions such as Rheumatoid Arthritis, Multiple Sclerosis, Hepatitis-C, Cancer, Transplant, etc. (excluding insulin).

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before the plan covers the drug that your physician may have initially prescribed. SFEHACL applies NO step therapy requirements for your drugs.

Supplemental Security Income (SSI) – This is 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.