APPENDIX I

ORGANIZATIONAL AND REFERENCE INFORMATION INTERROGATORIES

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ORGANIZATIONAL AND REFERENCE INFORMATION INTERROGATORIES

Respondent shall review and complete the interrogatories listed below in accordance with the instructions in RFP Section I.D.4. and provide Respondent's answer for **both HealthSelect PDP and HealthSelect Medicare Rx PDP** following each question. For purposes of including requested documents, Respondent shall provide them in the order and format requested in the Proposal Deliverables Checklist in RFP Section XII.D.1. Respondent shall recover any costs related to the RFP and Contract requirements only through Respondent's Price Proposal, **Appendix Q**.

A. Interrogatories – Organizational Information

A.1. **Authorized Representatives.** Provide the following information for Respondent's Authorized Representatives. This shall include, at a minimum, the individuals listed on the Incumbency Certificate discussed at RFP Section IV.A.2.

A.1.a. **HealthSelect PDP:**

Name:	Roger Holland
Title:	Vice President Sales, Public Sector
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	roger_holland@express-scripts.com
Telephone number:	949.499.2042
Name:	Amy Bricker
Title:	President, Express Scripts PBM
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	Amy@express-scripts.com
Telephone number:	314.684.6730
Name:	Fred Bendana
Title:	Vice President Sales
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	fbendana@express-scripts.com
Telephone number:	314.956.9518

A.1.b. **HealthSelect Medicare Rx PDP, if different from HealthSelect PDP information provided above:**

No difference.

A.2. **Contact List.** Provide the following information, in full, for each of Respondent's personnel listed below:

- Primary contact for purposes of this RFP (including the individual responsible for preparing and is authorized to sign Respondent's Clarification responses);
- Person responsible for preparing the Price Proposal (**Appendix Q**);
- Account Manager;
- Chief Security Officer;
- Privacy Officer; and
- Legal Counsel for purposes of the RFP and general Contract negotiations and performance purposes, and for representing Respondent at administrative hearings, litigation and subrogation.

A.2.a. **HealthSelect PDP**:

Name:	Roger Holland
Title:	Vice President Sales, Public Sector
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	roger_holland@express-scripts.com
Telephone number:	949.499.2042
Mobile number:	949.412.1440
Name:	Ryan Exley
Title:	Risk & Underwiting, Senior Director
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	RJExley@express-scripts.com
Telephone number:	615.595.3276
Mobile number:	423.637.1948
Name:	Brian Fisher
Title:	Account Manager
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	BFISHER@express-scripts.com
Telephone number:	216.317.8622
Mobile number:	216.317.8622

Name:	James Beeson
Title:	Chief Security Officer
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	James.Beeson@Cigna.com
Telephone number:	860.226.0598
Mobile number:	860.226.0598
Name:	Kim Piant
Title:	Privacy Officer
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	KJPiant@express-scripts.com
Telephone number:	314.692.1995
Mobile number:	314.692.1995
Name:	Ben Bradshaw
Title:	Legal Counsel
Mailing address:	One Express Way St. Louis, MO 63121
Email address:	benton.bradshaw@evernorth.com
Telephone number:	314.996.0900
Mobile number:	314.996.0900

A.2.b. **HealthSelect Medicare Rx PDP, if different from HealthSelect PDP information provided above:**

No difference.

A.3. **Site Visit Information.** In the event that Respondent is selected as a Finalist, ERS may request a site visit to Respondent's operational headquarter facility(ies), Call Center/customer service facility(ies), information systems data center facility(ies) and/or security operations center(s), as applicable. To better assist ERS with future travel arrangements, Respondent shall provide the following information:

A.3.a. **HealthSelect PDP**:

Physical address of the operational headquarters facility(ies):	One Express Way St. Louis, MO 63121
Physical address of the Call Center and customer service facility(ies):	4700 N. Hanley Rd. Saint Louis, MO 63134

Physical address of the information systems data center facility(ies) (the facility(ies) in which ERS' data will be housed; this location must not be a disaster recovery location):	Primary Data Center: QTS Facility 101 Possumtown Road Piscataway, NJ 08854 Secondary Data Center: Digital Reality Trust Facility 2200 Busse Road Elk Grove Village, IL 60007 Our Secondary Data Center is our Disaster Recovery site as well. We perform electronic vaulting for our backups over our internal private network to a virtual tape library system. While we do perform redundancy capability from our Primary to our Secondary data centers, the back ups are performed separately, with daily incremental backups and weekly full backups. No physical tapes are created.
Physical address of the security operations center:	1 Express Way St. Louis, MO 63121

A.3.b. **HealthSelect Medicare Rx PDP, if different from HealthSelect PDP information provided above:**

No difference.

A.3.c. Respondent shall indicate if ERS is required to execute a nondisclosure agreement prior to the site visits and, if so, each facility that requires a nondisclosure agreement.

A.3.c.i. If a nondisclosure agreement is required, Respondent shall provide a copy of Respondent's nondisclosure agreement.
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

An executed nondisclosure agreement is required if ERS visits our data and security centers.

A.4. **Organizational Charts.** Provide the following organizational charts:

A.4.a. An organizational chart that identifies any parent and/or holding company, affiliate, subsidiary, or other related entity that will be involved in providing the Services (including any entity to which fees will be sent and any entity for which financial statements are provided) and describes the services provided by each entity.

A.4.a.i. **HealthSelect PDP:**
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

A.4.a.ii. **HealthSelect Medicare Rx PDP, if different from HealthSelect PDP information provided above:**
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

No difference.

A.4.b. A company organizational chart identifying any internal department(s) that will have responsibility for the Services describing each department's role in providing the Services.

A.4.b.i. **HealthSelect PDP**:
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

A.4.b.ii. **HealthSelect Medicare Rx PDP, if different from HealthSelect PDP information provided above:**
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

No difference.

A.4.c. An organizational chart for Respondent's information technology department. If Respondent outsources Respondent's information technology functionality to third-party vendors, provide the name and address of all such vendors and specify the exact functions outsourced.

A.4.c.i. **HealthSelect PDP:**
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

A.4.c.ii. **HealthSelect Medicare Rx PDP, if different from HealthSelect PDP information provided above:**
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.
If unable to provide or if this is not applicable, check here and explain.

No difference.

A.4.d. An organizational chart containing the titles of all staff members and independent contractors that will perform any function related to the Services.

A.4.d.i. **HealthSelect PDP:**
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

In addition to our in-house capabilities described throughout this proposal, Express Scripts uses subcontractors to support various services. A list of subcontracted vendors/services is included.

A.4.d.ii. **HealthSelect Medicare Rx PDP, if different from HealthSelect PDP information provided above:**
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

No difference.

A.5. **Historically Underutilized Businesses.** As appropriate, Respondent shall provide the following information for both HealthSelect PDP and HealthSelect Medicare Rx PDP:

Not applicable.

A.5.a. If Respondent is certified as a HUB, provide the CPA's Vendor Identification Number or state "N/A".

N/A

A.5.b. ERS has not readily identified subcontracting opportunities; however, if Respondent is using HUBs, provide the applicable information for such HUBs or state "N/A".
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

Express Scripts is not using HUBs in performance of this contract.

A.5.c. If Respondent qualifies as a HUB (see https://comptroller.texas.gov/purchasing/vendor/hub/), but is not currently registered as a HUB, is Respondent willing to register as a HUB?
☐ Yes ☐ No ☒ N/A (Respondent does not qualify as a HUB) ☐ N/A (Respondent is already a registered HUB)

A.6. **Ownership Structure.** With regard to Respondent's ownership structure, check all that apply:

A.6.a. **Health Select PDP:**

☐ Corporation – Private
☒ Corporation – Publicly Traded
☐ Partnership
☐ Employee-owned
☐ Joint Venture
☐ Subsidiary of:
☐ Affiliate of bank
☐ Insurance company
☐ Broker
☐ Other (describe):

A.6.b. **HealthSelect Medicare Rx PDP, if different from HealthSelect PDP information provided above:**

☐ Corporation – Private
☒ Corporation – Publicly Traded
☐ Partnership
☐ Employee-owned
☐ Joint Venture
☐ Subsidiary of:
☐ Affiliate of bank
☐ Insurance company
☐ Broker
☐ Other (describe):

A.7. **Confidential and/or Proprietary Information Submission.** Per RFP Sections XII.B.1. – XII.B.1.b., Respondent shall confirm that it has uploaded the following to Bonfire, as applicable:

A.7.a. One (1) zipped folder labeled "**PBM Proposal – Public Information**" that contains all information Respondent considers public. Respondent shall not place any documents in this folder that are not otherwise uploaded under Requested Information in Bonfire.

☒ Uploaded (Only required if Respondent includes confidential and/or proprietary information in its Response)

☐ Not applicable (Not required if Respondent only includes public information in its Response)

A.7.b. One (1) zipped folder labeled "**PBM Proposal – Confidential and-or Proprietary Information**" that contains all information Respondent considers confidential and/or proprietary. Respondent shall not place any documents in this folder that are not otherwise uploaded under Requested Information in Bonfire.

☒ Uploaded (Only required if Respondent includes confidential and/or proprietary information in its Response)

☐ Not applicable (Not required if Respondent does not include confidential and/or proprietary information in its Response)

A.7.c. One (1) document titled "Confidential and-or Proprietary Information List" uploaded to Bonfire that lists everything Respondent considers to be confidential and/or proprietary information. Alternatively, if Respondent includes only public information in its Proposal, Respondent shall upload one (1) document titled "No Confidential or Proprietary Information" to Bonfire.

☒ Uploaded a document titled "Confidential and-or Proprietary Information List" that lists everything Respondent considers to be confidential and/or proprietary information.

☐ Uploaded a document titled "No Confidential or Proprietary Information" to Bonfire that states nothing in Respondent's Response is deemed by it to be confidential and/or proprietary.

B. Interrogatories – References

For purposes of providing the information in Sections B.1. – B.2.b., ERS prefers responses be provided at time of Proposal submission. However, if Respondent is not able to provide it at time of Proposal submission, Respondent **must provide the information within 24-hours of ERS' request should Respondent become a Finalist.**

B.1. **Top Clients.** Respondent shall provide information for Respondent's top six (6) current clients based on number of covered lives serviced for whom Respondent provides commercial PDP services and EGWP + Wrap services similar to the Services required in the RFP. Respondent shall provide three (3) clients for each PDP type. Respondent must have also been performing services for these clients for at least three (3) years.

Respondent may duplicate the table below for each client provided. For these six (6) clients, Respondent shall provide the following:

B.1.a. **Commercial PDP (three (3) clients):**

Company name:	State of South Carolina Public Employee Benefit Authority
Account primary contact:	Laura Smoak
Title:	Director
Email address:	lsmoak@peba.sc.gov
Telephone number:	803.521.0086
Number of covered lives enrolled in the plans:	426,189
Services provided:	PBM Services
Company name:	Commonwealth of Massachusetts Group Insurance Commission
Account primary contact:	Paul Murphy
Title:	Director of Operations
Email address:	Paul.murphy@state.ma.us
Telephone number:	617.727.2310
Number of covered lives enrolled in the plans:	312,896
Services provided:	PBM Services
Company name:	Missouri Consolidated Health Plan
Account primary contact:	Denise Chapel
Title:	Director of Vendor Relations
Email address:	denise.chapel@mchcp.org
Telephone number:	573.526.4016
Number of covered lives enrolled in the plans:	74,760
Services provided:	PBM Services

B.1.b. **EGWP + Wrap PDP (three (3) clients):**

Company name:	SC PEBA EGWP
Account primary contact:	Laura Smoak
Title:	Director
Email address:	lsmoak@peba.sc.gov
Telephone number:	803.521.0086
Number of covered lives enrolled in the plans:	91,485
Services provided:	PBM Services
Company name:	Commonwealth of Virginia
Account primary contact:	Gary Johnston
Title:	Director
Email address:	Gary.johnston@dhrm.virginia.gov
Telephone number:	804.371.7932
Number of covered lives enrolled in the plans:	31,367
Services provided:	PBM Services
Company name:	Missouri Consolidated Health Plan
Account primary contact:	Denise Chapel
Title:	Director of Vendor Relations
Email address:	denise.chapel@mchcp.org
Telephone number:	573.526.4016
Number of covered lives enrolled in the plans:	74,760
Services provided:	PBM Services

B.2. **Public Sector Clients.** Respondent shall provide information for all group benefit organizations, within the last three (3) years, for whom Respondent has provided pharmacy benefit manager services in the public sector with membership of no less than 400,000 covered lives in commercial PDP and no less than 100,000 covered lives in Medicare Rx PDP. Respondent may duplicate the table below for each client provided. For each client, include the information requested in the table below:

B.2.a. **Commercial PDP:**

Company name:	SC PEBA
Account primary contact:	Laura Smoak
Title:	Director
Email address:	lsmoak@peba.sc.gov
Telephone number:	803.521.0086
Type of relationship:	Express Scripts has been providing pharmacy services since 2016.
Number of covered lives enrolled in the plans:	426,189
Services performed for Client:	PBM Services

Company name:	Department of Defense
Account primary contact:	Henry Gibbs
Title:	Branch Chief, Purchased care Branch
Email address:	Henry.J.Gibbs.civ@mail.mil
Telephone number:	703. 681.8761
Type of relationship:	Express Scripts has been providing pharmacy services for this set of lives since 2015
Number of covered lives enrolled in the plans:	9 million lives
Services performed for Client:	PBM Services

B.2.b. **EGWP + Wrap PDP:**

Company name:	State Teachers Retirement System of Ohio
Account primary contact:	Greg Nickell
Title:	Director, Health Care Services
Email address:	nickellg@strsoh.org
Telephone number:	614.227.4041
Type of relationship:	Express Scripts has been providing pharmacy services since 2010.
Number of covered lives enrolled in the plans:	101,458
Services performed for Client:	PBM Services

Responses to Sections B.3. – B.3.b. shall be provided at time of Proposal submission. If this is not applicable to Respondent, then Respondent shall respond "Not Applicable."

Not applicable.

B.3. **Client Due Diligence.** Respondent shall provide information for Respondent's five (5) most recent client contracts for PDP services that were terminated for any reason before the anticipated contract end date. Respondent may duplicate the table below for each contract provided. For each contract, include the information requested in the table below:

Not applicable.

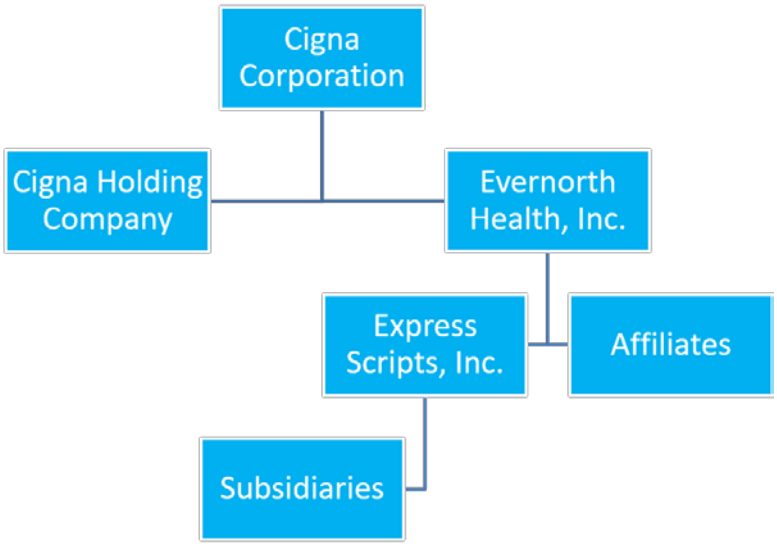
Appendix H, Section E.1.e

Parent or Sponsor Organizational Chart

The following list identifies our most significant subsidiaries, affiliates, and their primary businesses:

- Express Scripts, Inc., Medco Health Solutions, Inc. (affiliate) — Pharmacy benefit management (PBM) contracting entities
- Express Scripts Senior Care Holdings, Inc., (subsidiary) Medco Containment Life Insurance Company, and Medco Containment Insurance Company of New York (affiliates) — Medicare Part D PBM services
- ESI Mail Pharmacy Service, Inc. (subsidiary) and Express Scripts Pharmacy, Inc. (affiliate) — Home delivery pharmacy services
- Accredo Health Group, Inc. (affiliate) — Specialty pharmacy services, related nursing support services, and related services through Therapeutic Resource Centers®
- eviCore healthcare (subsidiary) — Medical benefits management (MBM) solutions
- Express Scripts Canada Holding Co. (subsidiary) — Health benefit management (HBM) services to Canadians
- Freedom Fertility Services (subsidiary) — Pharmacy specializing in the delivery of women's health products
- CuraScript SD Specialty Distribution (subsidiary) — Wholesale distributor of specialty drugs
- CareContinuum (subsidiary) — Medical benefit management services
- InsideRx (subsidiary) — Prescription savings programs
- MyMatrixx (subsidiary) — Worker's Compensation pharmacy services

The below chart illustrates the organization of the combined company.



Account Team Organizational Chart

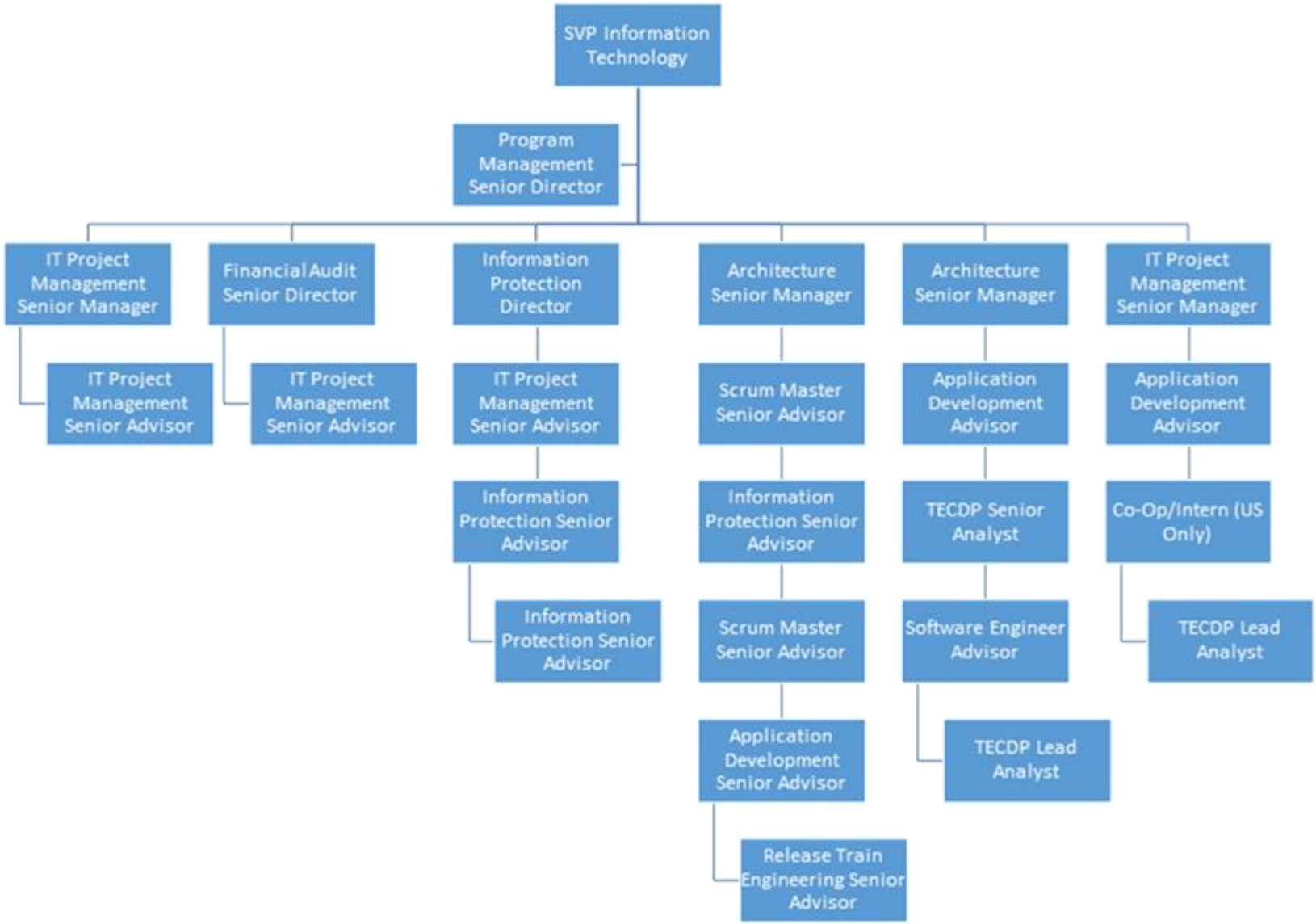
Account Team

- Jon Molberg, Dedicated Senior Account Executive
- Brian Fisher, Dedicated Senior Account Manager
- Bryan Hammons, Senior Clinical Account Executive
- Actuarial Financial Analyst
- Dedicated Communications Specialist
- EGWP Strategist
- Amy Bricker, Executive Sponsor

Enterprise Support Areas

- Information Technology
- Eligibility
- Reporting & Analytics
- Contact Center
- Plan Design & Support
- Enrollment Analyst

EXPRESS SCRIPTS®


SVP Information Technology
Program Management Senior Director
IT Project Management Senior Manager
Financial Audit Senior Director
Information Protection Director
Architecture Senior Manager
Architecture Senior Manager
IT Project Management Senior Manager
IT Project Management Senior Advisor
IT Project Management Senior Advisor
IT Project Management Senior Advisor
Scrum Master Senior Advisor
Application Development Advisor
Application Development Advisor
Information Protection Senior Advisor
Information Protection Senior Advisor
TECDP Senior Analyst
Co-Op/Intern (US Only)
Information Protection Senior Advisor
Scrum Master Senior Advisor
Software Engineer Advisor
TECDP Lead Analyst
Application Development Senior Advisor
TECDP Lead Analyst
Release Train Engineering Senior Advisor

Appendix J, Section E.28 – Mail Order Pharmacy Audit

Express Scripts considers our internal mail order pharmacy audits proprietary. Our Internal Audit has an overall audit plan for the enterprise that is developed based on risk assessment. The scope and frequency of evaluations depend primarily on an assessment of risks and the effectiveness of ongoing monitoring procedures. Express Scripts mail and specialty pharmacy locations could be identified for an audit under the risk assessment approach; however, there is not a standard expectation that the Internal Audit department performs audits of the pharmacy locations on a regular basis.

2022 Express Scripts FWA Work Plan

Fraud Waste and Abuse Triage Process

Express Scripts maintains a Fraud Tip Hotline which is available for FWA-specific concerns to be reported. This resource is also available internally to members of the Workforce, or external parties like members and providers. It can be accessed via phone (866-216-7096) or email (FraudTip@express-scripts.com). This information is posted on the Express Scripts intranet webpage as well as the external-facing Express Scripts website. Members also receive information regarding the Fraud Tip line at least annually with their Explanation of Benefit mailings.

Independent of the SIU, the Fraud Tip Analyst manages both the voicemail and email hotline to determine whether the communication appears to be an FWA-related issue or not before moving to the SIU Analyst for further review. Tips not related to FWA are reviewed, documented and then triaged to the appropriate department at Express Scripts, e.g. customer service, mail order, corporate security. The tips related to FWA are managed by the SIU.

Potential FWA cases can come to the SIU through either proactive analytics or fraud tips. Regardless of its origin, once a case arrives at the SIU, an SIU analyst conducts a preliminary investigation. The preliminary investigation includes a review of claims activity related to the specific issue in order to determine whether a full investigation is warranted. This preliminary investigation is initiated as quickly as possible, but not later than 14 days after the date the potential noncompliance has been identified.

If a preliminary investigation suggests that further investigation is warranted, the case is transferred to the SIU investigations team for full investigation. Full investigations can include detailed claims reviews, outreach to pharmacies and prescribers, and a review of external sources such as state enforcement agency records and media outlets. Investigations are worked aggressively and written updates must be made to investigation files at least every 21 days.

Fraud Risk Monitoring Activities

Network Pharmacy Monitoring Activity

Daily Pharmacy Monitoring (Daily Report) – Pharmacy line level summary report for any pharmacy that has been in the network in the past 6 months. The summary data includes pharmacy name and location information as well as a multitude of other data points noted as concern in previous pharmacy fraud cases. There are more than 60 data points that can indicate suspicious activity and include; *average ingredient cost, rejected claim count, reversal claim count, average distance between members and pharmacy, sum of paid, claim count, percent of claim count attributed to claims with a dispensed as written code, percent of claim count with a prior authorization*, and many more. This monitoring facilitates peer comparisons among pharmacies in the same state and with the same pharmacy type code. This query facilitates the production of the following models:

- **High AWP Scheme** – Used to identify pharmacies that are egregiously billing what are deemed to be high AWP drugs.
- **Diabetic Testing Supplies –** Will identify pharmacies billing a high number of specific diabetic testing supplies known to have been used in fraud schemes.
- **Commonly False Billed Medications –** Identifies pharmacies that are billing a large number of NDCs that are noted to be false billed through previous cases. Typically, these drugs are high dollar brand medications with an assumed high acquisition price.
- **Average Ingredient Cost (claim count / sum of paid)** - Assumption that a certain dollar amount on an Average Ingredient Cost or Cost Per Claim for retail pharmacies could suggest false billing.
- **Refill Rate** - Comparison of refill rate of pharmacies to their peers determined by geographic area and size of pharmacy.
- **Pharmacy Utilization Spikes** - Month over month comparison of utilization trending of a pharmacy and targeted using deviation from the mean.
- **Medicare Part D %** - Evaluate percentage of Medicare Part D compared to the book of business. Assumption that pharmacies with an extremely high % of Medicare has potential for false billing.

Member Migration (Daily Report) –This model runs every member that had a claim at a terminated pharmacy and then cross references those patient IDs with other pharmacies in the network. If there is a high number of members and a significant number of different termed pharmacies, this pharmacy in question is identified for further review.

Suspect Adjudication Schemes (Weekly Report) –This model identifies when there is a particular sequence of claim events that happen in a very short window of time. The sequence is always for the same member and pharmacy but can be for different drug and prescription numbers. Additionally, the sequences contain paid, reversal and rejected claims.

- **Step Therapy Circumvention –** Member brings in a prescription; however, that prescription requires a step therapy to be satisfied. Pharmacy artificially satisfies the step therapy requirement to allow the originally requested claim to pay.

- **Deductible Circumvention** – Similar to the step therapy model above this model also looks for a specific sequence of claim submissions by a pharmacy where the pharmacy avoids cost share requirements by submitting and reversing decoy claims.

Early Spike Alert – This model identifies sudden increases in utilization for particular medications. This sudden change in billing often identifies changes of ownership which can be indicative of FWA.

Purchase Verification – This model identifies pharmacies who may be the most likely to be short if a purchase verification was conducted, based off of prior purchase verification data.

Member Monitoring Activity

Suboxone + Pain - This model is used to find members who are receiving Suboxone and an opioid pain medication concurrently during a six month time period.

Stockpiling - This model is used to find members who are accumulating medications and exceeding a day supply of 280 in a six month time frame (i.e. 180 days).

Duplication of Services - This model is used to find members who are concurrently receiving medications within the same generic drug name or group of similar medications from multiple prescribers during a four month time period. This model has been enhanced with the addition of a predictive model that aims to reduce false positives due to coordination of care. The following medication groups are considered:

- Actiq (fentanyl)
- ADHD
- Alprazolam
- Anaphylaxis
- Androgenic Agents
- Antiemetic/Vertigo Agents
- Antihyperlipidemic
- Antitussives
- Asthma
- Azithromycin
- Barbiturates
- Biologic
- Botox
- Clonazepam
- Contraceptives - Oral
- COVID Test
- COVID Vaccine
- Dexamethasone
- Diabetic Needles
- Diazepam
- Diarrhea
- Diet Medications
- Erectile Dysfunction
- Gabapentin
- Headache Medication Containing Butalbital
- Headache Medication Specifically Indicated for Migraines
- Hepatitis C Meds
- HGH
- HIV
- Infection - Bacterial
- Infection – Fungal
- Inhalers
- Insulin
- Ivermectin
- Lancets
- Lidocaine
- Lorazepam
- Lyrica
- Malaria

- Meters
- Muscle Relaxers
- Narcan/Evzio
- Nasal Sprays
- Pain Medications
- PPE Gloves
- PPE Masks
- Seroquel
- Sleep Meds
- Soma
- Suboxone / Zubsolv
- Subsys
- Tamiflu
- Temazepam
- Test Strips
- Topamax
- Vimpat
- Wellbutrin

APAP- Acetaminophen - This model is used to find members who are receiving doses of acetaminophen which are over the max daily dose for a six month time frame and in result may pose a potential safety concern.

Body Building (including HGH) - This model is used to find members and prescribers (through the common prescriber query) who obtain/prescribe multiple medications that are typically used off label for muscle growth and physical appearance during a year's time frame.

Cocktail - This model is used to find members who are concurrently receiving specific medications that make up the following cocktails:

- Florida Cocktail = Valium (diazepam) or Xanax (alprazolam) + Flexeril (cyclobenzaprine) + CIII pain medication
- Holy Trinity = Xanax (alprazolam) + Soma (carisoprodol) + CII pain medication
- Houston Cocktail = Xanax (alprazolam) + Soma (carisoprodol) + CIII pain medication
- Soma Coma = codeine containing medications and Soma (carisoprodol)
- Las Vegas Cocktail = hydrocodone-apap medications and Soma (carisoprodol)
- Rozerem (ramelteon) + Suboxone (buprenorphine)

Drug Exposure – This model is used to identify medications that are on the rise with respect to prescribing trends that may lend themselves to possible fraud schemes. The model is ran for 12 months.

DSB RM – This model is used to find members who line up with the logic utilized in the rational med program that generates alerts based on day supply, claim count, and prescriber counts

ER - This model is used to find members who are frequenting multiple ER/Urgent Care prescribers/locations and receiving prescription claims in a short period of time. The medical costs associated with these visits are costly to the client. The model takes both controls and non-controls into consideration over a three month time frame.

Kids Pain Meds - This model is used to identify individual claims for children (12 years and younger) that are receiving tablet form pain medication. The review period is six months.

Manual Claims - This model is used to identify individual claims for any member submitting manual claims within a six month time frame.

Max Daily Dosage - This model is used to find members who are exceeding the max daily dose of the following medications for an average of six months which can be a potential safety concern and possibly a diversion attempt:

- Xanax (alprazolam) - 10 mg
- Xanax XR (alprazolam) - 10 mg

- Klonopin (clonazepam) - 20 mg
- Valium (diazepam) - 40 mg
- Ativan (lorazepam) - 10 mg
- Restoril (temazepam) - 30 mg
- Ambien (zolpidem) - 10 mg
- Ambien CR (zolpidem) - 12.5 mg
- Lunesta (eszopiclone) - 3 mg
- Soma (carisoprodol) - 1400 mg
- Ultram (tramadol) - 400 mg
- Ultram ER (tramadol) - 300 mg
- Neurontin (gabapentin) - 3600 mg

Morphine Equivalent Dose (MED) Gauge for Fentanyl Patches - This model identifies members with a fentanyl patch exposure. This model is ran monthly and looks back over a six month time frame.

Morphine Equivalent Dose (MED) Gauge for Methadone - This model identifies members with methadone exposure. This model is ran monthly and looks back over a six month time frame.

Morphine Equivalent Dose (MED) Gauge for Oxycodone HCL - This model identifies members with oxycodone exposure. The model is ran monthly and looks back over a six month time frame.

Morphine Equivalent Dose (MED) Gauge for Subsys - This model identifies members with Subsys exposure. The model is ran monthly and looks back over a six month time frame.

Narcan and Pain - This model is used to find members who are receiving Narcan and an opioid pain medication concurrently during a six month time period. The model excludes tramadol from the pain medications. The model gives a monthly count of when the Narcan and pain meds are being duplicated.

Suboxone and Pain - This model is used to find members who are receiving Suboxone and an opioid pain medication concurrently during a six month time period. The difference between this and the model version is that it eliminates the tramadol false positive and also give a monthly count of when the Suboxone and pain meds are being duplicated.

Prescriber Monitoring Activity

Alprazolam 2mg - This model identifies prescribers with a high percentage of alprazolam 2mg. This model is ran monthly and looks back over a six month time frame.

Control Ratio - This model identifies prescribers who have a high percentage of controlled substances on their profile. This model is ran monthly and looks back over a six month time frame.

Common Doc - This model identifies prescribers from the output of a member query that are common amongst the outliers of the member model. For large set of patient ID's utilize the MWAD table set up for housing large amounts of ID's This model is ran monthly and looks back over a six month time frame.

Family Prescribing - This model is used to identify those prescribers who are prescribing the same or similar medications to multiple patients under the same membership ID. The current medications reviewed are ADHD, compounds, Narcan, and pain medications. The model is ran monthly and looks back over a six month time frame.

Hydrocodone-APAP 10-XXX - This model identifies prescribers with a high percentage of hydrocodone-apap 10-xxx. This is the highest strength; the strength of the APAP can vary. The model is ran monthly and looks back over a six month time frame.

Oxycodone-APAP 10-XXX - This model identifies prescribers with a high percentage of oxycodone-apap 10-xxx. This is the highest strength; the strength of the APAP can vary. The model is ran monthly and looks back over a six month time frame.

Oxy Doc - This model identifies prescribers with a high percentage of oxycodone hcl 15mg and/or oxycodone hcl 30mg. These are two of the more abused strengths of oxycodone. The model is ran monthly and looks back over a six month time frame.

Self-Prescribing - This model identifies who may be overprescribing themselves medications.

Spike - This model identifies possible spikes in prescribing for any medication that shows a trend of increasing in prescribing. This model is ran monthly and looks back over a six month time frame.

Suboxone 100 - This model is used to find prescribers who have prescribed Suboxone (buprenorphine) to more than 100 patients during a six month time period. Outliers are then checked against the buprenorphine website (http://www.buprenorphine.samhsa.gov/) to determine if they are indicated to prescribe for the treatment of opioid addiction. Per the website, prescribers may treat up to 100 patients. This model is ran monthly and looks back over a six month time frame.

Subsys - This model identifies prescribers who have at least one patient receiving a Subsys. The model is ran monthly and looks back over a six month time frame.

Special Monitoring Activities for 2022

Target Copayment and Marketing in Pharmacy Investigations	Conduct targeted, survey focused inquiries of pharmacies where data suggests abuse of copayment or marketing policies to quickly identify investigative targets and best practices for monitoring.
Telemedicine Partnership	Combine investigative resources across member, prescriber, and pharmacy to ensure all aspects of telemedicine fraud are addressed.
Prescriber Spike Enhancement	Continue to enhance our prescriber spike model to identify the most egregious entities and further eliminate false positives.

Over-prescribing	Continue to monitor prescribers writing narcotics and dangerous drug combinations. Continue to identify new drug and drug combinations of concern.
Client Targeting	Expand effort to identify prescribers and pharmacies that may be targeting clients.
Proactive Fraud Trend Identification	Enhance efforts to monitor macro trends as they may relate to potential FWA.
General Pharmacy Predictive Model	Create a machine learning model to proactively identify pharmacies who may be outliers billing fraudulently.

Covid-19 Monitoring Activities

Inappropriate Use of Anti-Viral & Other Medications	Review prescribing patterns for Antivirals, Antimalarial, HIV, Asthma, Vitamins, PPE, and other medications/items commonly associated with COVID-19.
Prescription Emergency Override Risk	Track trends & potential concerns related to COVID-19 emergency overrides entered by pharmacies.
Pharmacy COVID Testing	Identify Pharmacies who over utilize COVID-19 tests.
Vaccine Trends	Identify pharmacies, prescribers and members who are outliers for COVID-19 vaccinations.

The Express Scripts SIU will continue to monitor and assess risks associated with COVID-19 as information received from CMS, HHS-OIG, NHCAA and other external partners.

APPENDIX K

LEGAL REQUIREMENTS AND REGULATORY COMPLIANCE DEVIATIONS AND INTERROGATORIES

APPENDIX K
LEGAL REQUIREMENTS AND REGULATORY COMPLIANCE DEVIATIONS AND INTERROGATORIES

The Respondent shall review and complete the interrogatories listed below in accordance with the instructions in RFP Section I.D.4. and provide the Respondent's answer **for both HealthSelect PDP and HealthSelect Medicare Rx PDP** following each question. For purposes of including requested documents, Respondent shall provide them in the order and format requested in the Proposal Deliverables Checklist in RFP Section XII.D.1. Deviations instructions are located in RFP Sections I.D.3. – I.D.3.a.

A. Deviations to the Contractual Agreement, BAA, DSBNA and Performance Guarantees

A.1. In accordance with the specifications provided within RFP Sections IV.A.3.a. – IV.A.3.a.i., Respondent shall provide its proposed Deviations to the Contractual Agreement, BAA and DSBNA, if applicable, by providing redlined changes within **Appendices B, C and D**.

Confirmed.

A.2. In accordance with the specifications provided within RFP Section IV.A.7.a., Respondent shall provide its Deviations to the PGs, if applicable, by providing redlined changes within **Appendices G-1 and G-2.**

Confirmed.

B. Interrogatories – Legal Services and Litigation

Deviations to Sections B.1. – B.4. are not permitted.

Legal Analysis for Administrative Hearings and Court Proceedings.

B.1. PBM shall provide legal services and litigation support relating to the Programs, including but not limited to providing legal analysis in connection with the Programs administration; assisting and supporting ERS in administrative hearings and court proceedings; and advising ERS with respect to garnishments, lawsuits, and other applicable legal actions including providing records, affidavits and testimony as needed. PBM may be required to provide its own legal representation in administrative hearings, legal proceedings, and lawsuits when appropriate. PBM shall coordinate its legal services and legal support related to the Programs with ERS' Office of the General Counsel. The Respondent shall confirm that it will abide by these requirements if selected for Contract award.
☒ Confirm

Confirmed, with the understanding that nothing contained herein shall require Express Scripts to engage in the practice of law on behalf of ERS as defined by Texas Government Code Section 81.101.

Legal Disclosures

B.2. For Respondent and any of Respondent's officers, directors, parent companies, affiliates, and subcontractors and any person identified by Respondent who will be performing any service under the RFP and Contract, disclose all matters responsive to Sections B.2.a. – B.2.b.:

B.2.a. During the past five (5) years, all matters that:

B.2.a.i. Resulted in a felony conviction or included any allegation of criminal conduct, fraud, embezzlement, money laundering, a violation of any securities law or regulation, a violation of any fiduciary duty, or an intentional tort involving moral turpitude.

To the best of our knowledge, no individuals proposed to work on this contract have been convicted of, pled guilty to, or pled no contest to any felony or included in any allegation of criminal conduct, fraud, embezzlement, money laundering, a violation of any securities law or regulation, a violation of any fiduciary duty or intentional tort involving moral turpitude. Express Scripts has in place and requires its employees and subcontractors to undergo a rigorous background check process that includes a search of criminal records across numerous local, state, and federal databases. Discoverable felony convictions within the past seven years are generally disqualifying for the purposes of employment, unless otherwise inconsistent with applicable law.

B.2.a.ii. Involved any state or federal civil or criminal litigation, action, or prosecution; any regulatory proceeding or investigation; disciplinary action; violation of a rule of any self-regulatory organization; license revocation; or governmental inquiry.

Yes. Express Scripts and its affiliated companies are occasionally party to legal or administrative proceedings arising out of the ordinary course of our business. However, pending litigation will not impair our performance in a contract with ERS. Please refer to Form 10-K and Form 10-Q for an updated description of material legal proceedings.

B.2.b. All matters that would have a material adverse effect on the Respondent or the ability of Respondent to deliver the Programs' Services as described in the RFP.

No pending litigation will have an adverse effect on our performance in a contract with ERS.

B.3. For each matter disclosed in Sections B.2.a. – B.2.b.:

B.3.a. Indicate specifically whether the matter (i) resulted in a felony conviction or included an allegation of criminal conduct, fraud, embezzlement, money laundering, a violation of any securities law or regulation, a violation of any fiduciary duty, or an intentional tort involving moral turpitude; or (ii) would have a material adverse effect on Respondent or the ability of Respondent to deliver the Services as described in the RFP.

To the best of our knowledge, this is not applicable.

B.3.b. Provide a brief summary of each relevant claim asserted in the matter. The brief summary should provide sufficient information for ERS to understand the basic facts involved in the claim. **Respondent shall not refer ERS to any third-party websites or other sources in order for ERS to obtain this information.**

Please see below for a summary of our most recent legal and regulatory matters from our 10-Q filed in May of 2022.

D. Legal and Regulatory Matters

The Company is routinely involved in numerous claims, lawsuits, regulatory inquiries and audits, government investigations, including under the federal False Claims act and state false claims acts initiated by a government investigating body or by a qui tam relator's filing of a complaint under court seal and other legal matters arising, for the most part, in the ordinary course of managing a global health services business. Additionally, the Company has received and is cooperating with subpoenas or similar processes from various governmental agencies requesting information, all arising in the normal course of its business. Disputed tax matters arising from audits by the Internal Revenue Service or other state and foreign jurisdictions, including those resulting in litigation, are accounted for under GAAP guidance for uncertain tax positions. See Note 21 for additional information on tax matters.
Pending litigation and legal or regulatory matters that the Company has identified with a reasonably possible material loss and certain other material litigation matters are described below. For those matters that the Company has identified with a reasonably possible material loss, the Company provides disclosure in the aggregate of accruals and range of loss, or a statement that such information cannot be estimated. The Company's accruals for the matters discussed below under "Litigation matters" and "Regulatory Matters" are not material. Due to numerous uncertain factors presented in these cases, it is not possible to estimate an aggregate range of loss (if any) for these matters at this time. In light of the uncertainties involved in these matters, there is no assurance that their ultimate resolution will not exceed the amounts currently accrued by the Company. An adverse outcome in one or more of these matters could be material to the Company's results of operations, financial condition or liquidity for any particular period. The outcomes of lawsuits are inherently unpredictable and we may be unsuccessful in these ongoing litigation matters or any future claims or litigation.

Litigation Matters

Express Scripts Litigation with Anthem. In March 2016, Anthem filed a lawsuit in the United States District Court for the Southern District of New York alleging various breach of contract claims against Express Scripts relating to the parties' rights and obligations under the periodic pricing review section of the pharmacy benefit management agreement between the parties including allegations that Express Scripts failed to negotiate new pricing concessions in good faith, as well as various alleged service issues. Anthem also requested that the court enter declaratory judgment that Express Scripts is required to provide Anthem competitive benchmark pricing, that Anthem can terminate the agreement and that Express Scripts is required to provide Anthem with post-termination services at competitive benchmark pricing for one year following any termination by Anthem. Anthem claims it is entitled to $13 billion in additional pricing concessions over the remaining term of the agreement, as well as $1.8 billion for one year following any contract termination by Anthem and $150 million damages for service issues ("Anthem's Allegations").On April 19, 2016, in response to Anthem's complaint, Express Scripts filed its answer denying Anthem's Allegations in their entirety and asserting affirmative defenses and counterclaims against Anthem. The court subsequently granted Anthem's motion to dismiss two of six counts of Express Scripts' amended counterclaims.Express Scripts filed its Motion for Summary Judgment on August 27, 2021. Anthem completed filing of its Response to Express Scripts' Motion for Summary judgment on October 16, 2021. Express Scripts filed its Reply in Support of its Motion for Summary Judgment on November 19, 2021.

There is no tentative trial date.Medicare Advantage. A qui tam action that was filed by a relator in the United States District Court for the Southern District of New York in 2017 was unsealed on August 6, 2020. The action asserts claims related to risk adjustment practices arising from certain health exams conducted as part of the Company's Medicare advantage business. In September 2021, the qui tam action was transferred to the United States District Court for the Middle District of Tennessee. On January 11,2022, the U.S. Department of Justice ("DOJ") (U.S. Attorney's Offices for the Southern District of New York and the Middle District of Tennessee) filed a motion to partially intervene which is pending before the court. The Company has opposed the DOJ's motion to intervene and the government filed its reply brief on February 1,2022. The motion has been fully briefed and is under the court's review.

Regulatory Matters

Civil Investigative Demand. The DOJ is conducting industry-wide investigations of Medicare Advantage organizations' risk adjustment practices. For certain Medicare advantage organizations, including Cigna, those investigations have resulted in litigation (see above). The Company is currently responding to information requests(civil investigative demand) from the DOJ (U.S. Attorney's Office for the Eastern District of Pennsylvania). The Company is cooperating with the DOJ and has responded and continues to respond to its requests.

B.3.c. If Respondent did not provide any information for the preceding questions, confirm that Respondent has no responsive matters to disclose.
☐ Confirm

N/A

B.4. **Legal Responsibilities.** Confirm Respondent, if selected for Contract award, shall provide legal analysis in connection with the Programs' administration at no additional cost other than as specifically provided for in the Price Proposal (**Appendix Q**).
☒ Confirm

Confirmed, with the understanding that nothing contained herein shall require Express Scripts to engage in the practice of law on behalf of ERS as defined by Texas Government Code Section 81.101.

Contract Breakdowns and Performance Assessments

B.5. Provide a schedule and describe in detail previous contract implementation breakdowns, breaches of contract (including any performance assessments), and contract-related disputes resulting in suit or settlement during the **past five (5) years** (if any) by the Respondent and discuss all measures Respondent took to rectify the situation or remedy the breach. Respondent shall separate by governmental and non-governmental clients and indicate the reason for any implementation breakdown, the substance of any dispute, and/or the amount of any settlement amount paid. **List in reverse chronological order.**

- Governmental:
  Express Scripts is not aware of any governmental contract implementation breakdowns, breaches of contract, or contracted related disputes.

- Non-governmental:
  Express Scripts is not aware of any non-governmental contract implementation breakdowns, breaches of contract, or contracted related disputes. We are occasionally party to legal or administrative proceedings arising out of the ordinary course of our business.

- Reason for assessment:
  Not applicable.

- Action taken to resolve issue:
  Not applicable.

- Assessment amount paid:
  Not applicable.

B.5.a. If Respondent did not provide a schedule as outlined in Section B.5. above, confirm that Respondent has not been involved in any contract implementation breakdowns, breaches of contract (with or without performance assessments) or contract-related disputes resulting in suit or settlement described in Section B.5. above.
☐ Confirm

We are occasionally party to legal or administrative proceedings arising out of the ordinary course of our business. We provided a summary of our current pending litigation in our response above; additionally, it can be found Form 10-K and Form 10-Q for the most up-to-date description of material legal proceedings.

Mergers, Acquisitions or Sales

B.6. Provide a schedule and describe any proposed, pending or completed merger, acquisition, sale, joint venture or other similar transaction involving Respondent's organization, or any part of Respondent's organization that will provide the Services under the Contract, during the **past five (5) years** (if applicable). Include any transaction or financing that may result or has resulted in a change of control in Respondent's organization, or in the case of an acquisition, a change of control at the target organization.

Due to confidentiality and legal constraints inherent in every potential merger, acquisition, or other major corporate transaction, Cigna is prohibited from commenting on any such business transaction activity. We will notify ERS of any such transaction to the extent that it does not violate our obligations as a publicly-traded company under applicable federal and state securities laws and regulations, as well as any specific confidentiality or other legal obligations to third parties.

We will continue to invest in innovative solutions and programs to engage and support members in their health and life journeys and partner with healthcare providers to lead value-based care programs. We will continue to expand our proven footprint and capabilities across the globe for individual and employer clients. Our approach of focusing on health care services over sick care financing has never been more critical.

We have provided our most recent acquisitions below:

MDLIVE (February 2021) — Evernorth entered into a definitive agreement to acquire MDLIVE, a leading 24/7 virtual care delivery platform. Together, we imagine a new end-to-end care experience to complement the way customers and patients interact with their existing providers. Our collaboration will enable earlier identification and diagnosis of critical care needs; faster and more seamless referrals to high-performing providers, including specialists and behavioral health providers; and more convenient access to appropriate, affordable sites of service, and pharmaceutical fulfillment. The transaction is subject to customary closing conditions, and is expected to close in the second quarter of 2021, subject to receipt of required regulatory approvals.

Verity Solutions (October 2019) — Verity Solutions is an award-winning leader in software and services developed for the administration of the federal 340B drug pricing program. This acquisition allowed us to offer a comprehensive range of 340B services. This includes 340B administration services from Verity Solutions and contract pharmacy services, including drug replenishment, dispensing, and inventory services, from Express Scripts, Accredo, and Freedom Fertility Pharmacy.

Express Scripts (December 2018) — Express Scripts enabled us to expand our health services portfolio, bringing industry-leading cost trend capabilities that positioned us to deliver better care and expand choice while driving down health care costs. With Express Scripts, we dramatically accelerated the number and breadth of our value-based relationships. This model of partnership aligns incentives to clinical outcomes, not just consumption of medication or health care services, which added to our rapidly expanding collaborative care network. We further strengthened these relationships by our comprehensive analytics platform, which utilizes insights from one billion annual customer touchpoints to drive transparency and engagement with clients and members.

Brighter, Inc. (December 2017) — Brighter emerged as one of health care's most innovative technology companies, working with leading health service and dental organizations to engage patients and providers in personalized and seamlessly integrated experiences to more efficiently deliver higher-value health care. The acquisition accelerated the development of our mobile and desktop platforms and created new end-to-end technologies that connect health consumers and providers with the guidance, support, and incentives they need to increase quality of care and maximize cost-savings.

eviCore healthcare (December 2017) — eviCore healthcare is the industry leader in evidence-based medical benefits management (MBM). eviCore healthcare offers a broad range of integrated MBM solutions with leading positions in radiology, cardiology, musculoskeletal disorders, post-acute care, and medical oncology. Among the capabilities eviCore healthcare brings is a broader ability to drive value in the use of specialty medications, which are used to treat complex and chronic conditions, and comprise the most expensive and fastest-growing portion of pharmaceutical spend. This acquisition positioned us to best manage the future of healthcare, including gene therapies, increased adoption of biosimilars, and personalized medicine.

myMatrixx (May 2017) — myMatrixx expanded our capability to offer best-in-class services to payers and injured workers while meeting the continued demand for customized pharmacy solutions for injured workers. This acquisition combined myMatrixx's strong reputation for client services, deep industry knowledge base, market agility, and best practices with our size and scale, ability to invest in sophisticated technology systems, and industry-leading clinical tools and utilization management strategies.

C. Interrogatories – Regulatory Compliance

Deviations to this section are not permitted.

Standing

C.1. Respondent is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from contracting with any federal, state or local department or agency.
☒ Confirm

C.1.a. Respondent is and shall continue to be in good standing in the state in which it was incorporated or formed.
☒ Confirm

C.1.b. If Respondent has ever had its authority to conduct business in any state revoked, cancelled, suspended or forfeited, it shall provide an explanation. If Respondent has not had its authority to conduct business in any state revoked, cancelled, suspended or forfeited, it shall answer this interrogatory "N/A."

N/A

C.1.c. Section 2252.152 of the Tex. Gov't Code prohibits ERS from awarding a contract to any person who does business with Iran, Sudan, or a foreign terrorist organization as defined in Section 2252.151 of the Tex. Gov't Code. Respondent certifies that it is not ineligible to receive the Contract.
☒ Confirm

Data Privacy and Security

C.2. Describe in detail Respondent's policies, procedures and/or systems used to ensure compliance with HIPAA and all other federal and state privacy and security laws.

In our dual role under HIPAA as a covered entity as a pharmacy provider and as our clients' business associate, Express Scripts dedicates significant corporate resources to achieving full compliance with HIPAA's Privacy and Security Rules and subsequent standards.

Specifically, as a covered entity, Express Scripts Pharmacy transmits information in specified formats and ensures that only the minimum amount of protected health information (PHI) is used to perform a defined set of activities. As a pharmacy benefit manager, Express Scripts has all systems, processes, and procedures in place to meet our business associate duties and responsibilities under HIPAA. Through our Business Associate Agreement, ERS can rest assured that we will meet our commitments under the appropriate HIPAA provisions.

Express Scripts has long maintained stringent policies and procedures to protect patient privacy and is strongly committed to safeguarding PHI in compliance with HIPAA privacy standards. To this end, Express Scripts:

- Requires employees and contractors to attend security awareness training annually
- Requires employees and contractors to attend privacy training annually
- Executes regular reviews and updates of privacy and security policies to ensure compliance with industry best practices and technology enhancements
- Arranges for routine security audits to ensure compliance with security policies and standards, including HITRUST certification
- Conducts regular security scans of servers and networks to detect and remediate vulnerabilities

Additionally, Express Scripts actively monitors appropriate legislative authorities for updates to existing regulations or issuance of new guidelines and regulations, such as HIPAA.

C.3. Provide a full description of any breach requiring notification to five hundred (500) or more individuals by the Gramm-Leach-Bliley Act or other federal or state law during the past five (5) years. For each, Respondent's description shall include, but not be limited to:

The identity of the entity that caused the breach:	Not applicable. Express Scripts has experienced no breach requiring notification to 500 or more individuals by the Gramm-Leach Biley Act or other Federal or State law during the past five years.
The date of the breach:	Not applicable.
A description of the breach:	Not applicable.
Any fines or penalties assessed against Respondent:	Not applicable.
The regulatory body that assessed any such fines or penalties:	Not applicable.
A description of actions or mitigation taken to prevent such a breach in the future:	Not applicable.

C.4. Provide a description of any breach involving notification to the affected individual during the past five (5) years that is not described in Section C.3. above. These may be summarized, but should give ERS a clear understanding of the number of breaches, the number or affected individuals per breach, the types of actions that led to the breaches, and any mitigation completed by Respondent to prevent such breaches in the future.

Not applicable.

Licenses and Registrations

C.5. Describe and confirm the validity of any license(s) and/or registration(s) that Respondent or any of its employees, independent contractors, or subcontractors are required to maintain in connection with the provision of the Programs' Services. Specifically identify any such licenses and registrations required by the State.

Our pharmacies are qualified to do business in all 50 states, as well as the following U.S. territories: American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands. These pharmacies are licensed in the states in which they reside and, depending on the functions they perform, hold non-resident licenses in other states, as required by applicable state law. We are in compliance with all applicable state and federal laws and regulations governing our business. Additionally, to assist our specialty pharmacies in the administration of infused therapies for our specialty patients, we hold Home health Agency licenses in those jurisdictions when required. Further, when required, our pharmacies hold Medicare and Medicaid provider numbers to submit claims to these government payer programs.

In regards to individual employees, those employees who in the performance of their individual job responsibilities are required to hold licensure or registrations undergo primary source verification of their licenses upon hire and then on a regular schedule basis to validate all licenses are active and in date.

Legal Entity Incorporation or Formation Information

C.6. Respondent will provide the following information for the organization(s) that will be providing the Programs' services. Include any entity holding any license or registration required to provide the Programs' services, as applicable.

HealthSelect PDP:

Organization full legal name:	Express Scripts, Inc.
Physical address of principal place of business:	One Express Way St. Louis, MO 63121
Mailing address (if different):	Not applicable.
Telephone number:	800.332.5455.
Website Address:	www.express-scripts.com
State in which Respondent incorporated or formed:	Delaware
Year in which Respondent incorporated or formed:	1992
Year in which Respondent became authorized to do business in Texas, if Texas is not its jurisdiction of incorporation or formation (if applicable):	Qualified in Texas as of 3/2/1987.

HealthSelect Medicare Rx PDP:

☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; the Respondent shall provide the relevant information in the table below for the organization that will be providing the Services for administration of the HealthSelect Medicare Rx PDP.

C.6.a. Respondent shall state the name of the contracting entity's registered agent in Texas and the address of registered office where service of process may be personally served on the registered agent in Texas. If the contracting entity does not have a registered agent in Texas, Respondent shall provide an explanation.

HealthSelect PDP:

Registered agent's full legal name: **CT Corporation System**
Physical address: **1999 Bryan Street, Suite 900** **Dallas, TX 75201**
Mailing address (if different): **N/A**
Telephone number: **214.979.1172**

HealthSelect Medicare Rx PDP:

No difference.

C.6.b. If Respondent provides Respondent's parent or sponsoring corporation's financial statements instead of Respondent's own financial statements to meet net worth requirements as discussed in the Minimum Requirements Questionnaire, **Appendix H**, Respondent shall choose one (1) of the two (2) options listed below:

☐ Respondent's parent or sponsoring corporation will co-sign or sign the Contract. If this choice is selected, the information for Respondent's parent or sponsoring corporation must be included in Section C.6.

☐ Respondent's parent or sponsoring corporation will provide a one hundred percent (100%) guarantee for Respondent's Contract performance as negotiated with ERS. If this option is selected, ERS will provide its guarantee agreement for Respondent's review. Respondent may redline the guarantee agreement according to the procedure described in RFP Section IV.A.3.a.i.

Per our response to E.1 in the Appendix H, Express Sripts confirms we have a current net worth of at least five hundred million dollars ($500 million) and at least $70 million in cash and cash equivalents available (on average); we will not be relying on our parent company.

C.7. If Respondent **is not incorporated** in Texas, proceed to Section C.8. If the Respondent **is incorporated** in Texas, provide copies of the following for each entity listed in Section C.6.:

C.7.a. Certificate of Formation (including any amendments).

HealthSelect PDP:
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☐ Provided ☒ If the document is the same as the one provided above, check here.

C.7.b. Certificate of status from Texas Secretary of State confirming the entity's registration in Texas. Information concerning registration may be found on the website for the Texas Secretary of State.

HealthSelect PDP:
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☐ Provided ☒ If the document is the same as the one provided above, check here.

C.7.c. Certificate of account status from CPA confirming that all franchise taxes due have been paid. Information concerning CPA account status may be found on the website for the Texas Comptroller of Public Accounts.

HealthSelect PDP:
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☐ Provided ☒ If the document is the same as the one provided above, check here.

C.7.d. Any assumed name certificate filed in Texas, if applicable.
HealthSelect PDP:
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☐ Provided ☒ If the document is the same as the one provided above, check here

C.8. If Respondent is **incorporated outside of Texas**, provide copies of the following for each entity listed in Section C.6.:

C.8.a. Certificate of Incorporation or other equivalent formation document (including any amendments) from the jurisdiction of formation.
HealthSelect PDP:
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☐ Provided ☒ If the document is the same as the one provided above, check here

C.8.b. Certificate of good standing from state of formation.
HealthSelect PDP:
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☐ Provided ☒ If the document is the same as the one provided above, check here

C.8.c. Certificate from the Texas Secretary of State confirming Respondent's registration as a For-Profit Corporation (or other applicable legal entity) in the State, or confirm that no such registration is required of Respondent. Information concerning registration may be found on the website for the Texas Secretary of State.
HealthSelect PDP:
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☒ Provided ☐ If the document is the same as the one provided above, check here

C.8.d. Certificate of account status from the CPA confirming that all franchise taxes due and payable have been paid, or confirm that the Respondent is not obligated to pay franchise tax in Texas. Information concerning CPA account status may be found on the website for the Texas Comptroller of Public Accounts.
HealthSelect PDP:
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☒ Provided ☐ If the document is the same as the one provided above, check here.

Data Sharing

C.9. As stated in RFP Section IV.A.6., ERS in its sole discretion may elect to have its data excluded from any type of data sharing arrangement. In order for ERS to better understand Respondent's background and business structure, Respondent shall provide the following information if it sells or reports any data from its current clients to others, either specifically or in aggregate:

HealthSelect PDP:

The arrangements for the data sharing:	Express Scripts will not use or disclose non-anonymous member data, except as related to our performance of pharmacy benefit management services, or as required by law or regulation. Express Scripts and our affiliates may use de-identified claims data (de-identified in accordance with Health Insurance Portability and Accountability Act [HIPAA] regulation), including drug data and related medical data collected by Express Scripts or provided to Express Scripts by ERS, for research; provider profiling; benchmarking; drug trend; cost and other internal analyses and comparisons; clinical, safety, and trend programs; ancillary supplies, equipment, and services (ASES); or other business purposes of Express Scripts or our affiliates, in all cases subject to applicable law. Any data that is produced as a result of Express Scripts' dispensing and processing claims through our owned and operated home delivery or specialty pharmacies is considered Express Scripts proprietary data.
The details of what data was shared, including how it is masked:	Express Scripts will not use or disclose non-anonymous member data, except as related to our performance of pharmacy benefit management services, or as required by law or regulation. Express Scripts and our affiliates may use de-identified claims data (de-identified in accordance with Health Insurance Portability and Accountability Act [HIPAA] regulation), including drug data and related medical data collected by Express Scripts or provided to Express Scripts by ERS, for research; provider profiling; benchmarking; drug trend; cost and other internal analyses and comparisons; clinical, safety, and trend programs; ancillary supplies, equipment, and services (ASES); or other business purposes of Express Scripts or our affiliates, in all cases subject to applicable law. Any data that is produced as a result of Express Scripts' dispensing and processing claims through our owned and operated home delivery or specialty pharmacies is considered Express Scripts proprietary data.
The measures taken to ensure the information is not identifiable:	Data is de-identified in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulation.

HealthSelect Medicare Rx PDP:
☒ Confirm same response as provided above for the HealthSelect PDP.
☐ Unable to confirm; the Respondent shall provide the information in the table below.

The arrangements for the data sharing:	
The details of what data was shared, including how it is masked:	
The measures taken to ensure the information is not identifiable:	

C.9.a. Respondent shall confirm that, unless specifically authorized in advance in writing by ERS, it shall not share ERS data or include ERS data in any data sharing arrangement.

HealthSelect PDP:
☒ Confirm
☐ If unable to confirm, provide an explanation.

HealthSelect Medicare Rx PDP:
☒ Confirm
☐ If unable to confirm, provide an explanation.

Previous State Employment

C.10. Pursuant to Tex. Gov't Code Sections 572.069 and 669.003, if any of the individuals who will perform the Programs' Services have been employed by ERS at any time during the two (2) years preceding the Proposal submission date or, in the case of a former Executive Director of ERS during the preceding four (4) years of the Proposal submission date, state the following:

Name of individual:	Not applicable.
Date of separation from ERS:	
Position with Respondent:	
Date of employment with Respondent:	

Appendix K, Section C.7.a – C.7.d

Per the instructions in the RFP (If Respondent is not incorporated in Texas, proceed to Section C.8. If the Respondent is incorporated in Texas, provide copies of the following for each entity listed in Section C.6) Express Scripts is not providing the requested Texas formation documents as we are not incorporated in Texas.

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF MERGER, WHICH MERGES:

"ARISTOTLE MERGER SUB, INC.", A DELAWARE CORPORATION,

WITH AND INTO "EXPRESS SCRIPTS, INC." UNDER THE NAME OF "EXPRESS SCRIPTS, INC.", A CORPORATION ORGANIZED AND EXISTING UNDER THE LAWS OF THE STATE OF DELAWARE, AS RECEIVED AND FILED IN THIS OFFICE THE SECOND DAY OF APRIL, A.D. 2012, AT 7:30 O'CLOCK A.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE NEW CASTLE COUNTY RECORDER OF DEEDS.

Jeffrey W. Bullock, Secretary of State

2292582 8100M

AUTHENTICATION: 9473221

120380414

DATE: 04-02-12

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 07:30 AM 04/02/2012
FILED 07:30 AM 04/02/2012
SRV 120380414 - 2292582 FILE

CERTIFICATE OF MERGER

OF

ARISTOTLE MERGER SUB, INC.,
a Delaware corporation,

WITH AND INTO

EXPRESS SCRIPTS, INC.,
a Delaware corporation

(Pursuant to Section 251 of the General Corporation Law of the State of Delaware)

Pursuant to Section 251(c) of the General Corporation Law of the State of Delaware (the "DGCL"), Express Scripts, Inc., a Delaware corporation ("Express Scripts"), in connection with the merger (the "Merger") of Aristotle Merger Sub, Inc., a Delaware corporation ("Aristotle Merger Sub"), with and into Express Scripts, hereby certifies as follows:

FIRST: The names and states of incorporation of the constituent corporations to the Merger (the "Constituent Corporations") are:

Name	State of Incorporation
Express Scripts, Inc.	Delaware
Aristotle Merger Sub, Inc.	Delaware

SECOND: An Agreement and Plan of Merger, dated as of July 20, 2011, as amended as of November 7, 2011 (and as the same may be amended by the parties thereto from time to time, the "Merger Agreement"), by and among Aristotle Holding, Inc., a Delaware corporation, Medco Health Solutions, Inc., a Delaware corporation, Express Scripts, Plato Merger Sub, Inc., a Delaware corporation and Aristotle Merger Sub, has been approved, adopted, executed and acknowledged by each of the Constituent Corporations and their respective stockholders in accordance with Section 251 of the DGCL, and with respect to Aristotle Merger Sub, in accordance with Section 228 of the DGCL.

THIRD: Express Scripts shall be the surviving corporation in the Merger. The name of the surviving corporation shall be Express Scripts, Inc.

FOURTH: The certificate of incorporation of Express Scripts shall be amended and restated upon the effectiveness of the Merger to read in its entirety as set forth on Exhibit A hereto, and as so amended and restated shall be the certificate of incorporation of the surviving corporation.

FIFTH: The Merger shall become effective upon the filing of this Certificate of Merger with the Secretary of State of the State of Delaware.

SIXTH: An executed copy of the Merger Agreement is on file at the office of the surviving corporation at:

One Express Way
St. Louis, MO 63121

SEVENTH: A copy of the Merger Agreement will be furnished by the surviving corporation, on request and without cost, to any stockholder of either of the Constituent Corporations.

* * * * *

IN WITNESS WHEREOF, the undersigned has caused this Certificate of Merger to be executed this 2nd day of April, 2012.

Express Scripts, Inc.,
a Delaware corporation

By: /s/ Keith J. Ebling
Name: Keith J. Ebling
Its: Executive Vice President, General Counsel and Corporate Secretary

Exhibit A

AMENDED AND RESTATED
CERTIFICATE OF INCORPORATION

OF

EXPRESS SCRIPTS, INC.

FIRST: The name of the Corporation is Express Scripts, Inc. (hereinafter the "Corporation").

SECOND: The address of the registered office of the Corporation in the State of Delaware is 2711 Centerville Road, Suite 400, Wilmington, County of New Castle, 19808. The name of its registered agent at that address is Corporation Service Company.

THIRD: The purpose of the Corporation is to engage in any lawful act or activity for which a corporation may be organized under the General Corporation Law of the State of Delaware as set forth in Title 8 of the Delaware Code (the "GCL").

FOURTH: The total number of shares of stock which the Corporation shall have authority to issue is 100 shares of Common Stock, having a par value of $0.01 per share.

FIFTH: The following provisions are inserted for the management of the business and the conduct of the affairs of the Corporation, and for further definition, limitation and regulation of the powers of the Corporation and of its directors and stockholders:

(1) The business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors.

(2) The directors shall have concurrent power with the stockholders to make, alter, amend, change, add to or repeal the By-Laws of the Corporation.

(3) The number of directors of the Corporation shall be as from time to time fixed by, or in the manner provided in, the By-Laws of the Corporation. Election of directors need not be by written ballot unless the By-Laws so provide.

(4) The Corporation shall indemnify to the fullest extent permitted by Section 145 of the GCL as amended from time to time each person who is or was a director or officer of the Corporation and the heirs, executors and administrators of such a person.

(5) No director shall be personally liable to the Corporation or its stockholders for monetary damages for breach of fiduciary duty as a director for any act or omission, except that he may be liable (i) for any breach of the director's duty of loyalty to the Corporation or its stockholders, (ii) for acts or omissions not in

good faith or which involve intentional misconduct or a knowing violation of law, (iii) under Section 174 of the GCL or (iv) for any transaction from which the director derived an improper personal benefit. Neither the amendment nor repeal of this Article Fifth (5), nor the adoption of any provision of the Certificate of Incorporation inconsistent with this Article Fifth (5), shall eliminate or reduce the effect of this Article Fifth (5) in respect of any matter occurring, or any cause of action, suit or claim that, but for this Article Fifth (5), would accrue or arise, prior to such amendment, repeal or adoption of an inconsistent provision.

(6) In addition to the powers and authority hereinbefore or by statute expressly conferred upon them, the directors are hereby empowered to exercise all such powers and do all such acts and things as may be exercised or done by the Corporation, subject, nevertheless, to the provisions of the GCL, this Certificate of Incorporation, and any By-Laws adopted by the stockholders; provided, however, that no By-Laws hereafter adopted by the stockholders shall invalidate any prior act of the directors which would have been valid if such By-Laws had not been adopted.

SIXTH: Meetings of stockholders may be held within or without the State of Delaware, as the By-Laws may provide. The books of the Corporation may be kept (subject to any provision contained in the GCL) outside the State of Delaware at such place or places as may be designated from time to time by the Board of Directors or in the By-Laws of the Corporation.

SEVENTH: The Corporation reserves the right to amend, alter, change or repeal any provision contained in this Certificate of Incorporation, in the manner now or hereafter prescribed by statute, and all rights conferred upon stockholders herein are granted subject to this reservation.

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "EXPRESS SCRIPTS, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TENTH DAY OF MAY, A.D. 2022.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

2292582 8300

Authentication: 203385702

SR# 20221875072

Date: 05-10-22

You may verify this certificate online at corp.delaware.gov/authver.shtml

Franchise Tax Account Status

As of : 05/25/2022 14:24:29

This page is valid for most business transactions but is not sufficient for filings with the Secretary of State

EXPRESS SCRIPTS, INC.	
Texas Taxpayer Number	14314205635
Mailing Address	1 EXPRESS WAY # HQ2E04 SAINT LOUIS, MO 63121-1824
Right to Transact Business in Texas	ACTIVE
State of Formation	DE
Effective SOS Registration Date	06/10/1992
Texas SOS File Number	0009178806
Registered Agent Name	C T CORPORATION SYSTEM
Registered Office Street Address	1999 BRYAN ST. SUITE 900 DALLAS, TX 75201

APPENDIX L

COMMUNICATION REQUIREMENTS DEVIATIONS AND INTERROGATORIES

APPENDIX L
COMMUNICATION REQUIREMENTS
DEVIATIONS AND INTERROGATORIES

Respondent shall review and complete the interrogatories listed below in accordance with the instructions in RFP Section I.D.4. and provide Respondent's answer **for both HealthSelect PDP and HealthSelect Medicare Rx PDP** following each question. If the responses specific to the HealthSelect PDP are different than those of the HealthSelect Medicare Rx PDP, Respondent shall describe those differences. For purposes of including requested documents, Respondent shall provide them in the order and format requested in the Proposal Deliverables Checklist in RFP Section XII.B. Deviations instructions are located in RFP Sections I.D.3. – I.D.3.a. Respondent shall recover any costs related to the RFP and Contract requirements only through Respondent's Price Proposal, **Appendix Q**.

A. Deviations – Scope of Work - Communication Requirements

A.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Communication Requirements*** described in RFP Sections V.A.1. – V.E.6.

☐ Affirm ☒ Affirm with the proposed Deviations

If applicable, enumerate and provide a detailed description of any Deviations between Respondent's response and these requirements:

Respondent's requested Deviations detail:

B.2.b. ERS shall retain the right to change or modify such material to accommodate ERS' specific needs.

Your dedicated communications specialist will work with ERS to customize and co-brand communications to meet your specific needs, except for standard operational documents, communications related to drug recalls, or when the health or safety of a member may be in jeopardy. Please note that certain CMS-model based communications cannot be customized.

B.5. Welcome Packets. PBM's welcome packets shall be produced and mailed to approximately 415,000 HealthSelect PDP Participants and 85,000 HealthSelect Medicare Rx PDP Medicare-eligible Participants at ERS' direction. New enrollment packets shall be mailed by PBM throughout the year to new Participants in the PDPs. These packet should contain, but not be limited to, the following materials: Welcome Letter; Annual Notice of Coverage (for HealthSelect Medicare Rx PDP welcome packets only); PDP-specific benefit plan descriptions/schedules of benefits; Link to the PDP prescription drug formulary; Link to pharmacy directory; Mail order pharmacy information; Link to PDP-specific drug cost estimator tool; and PBM's Customer Service Team's contact information.

Confirmed. Please note for ERS' EGWP population we do provide an Annual Notice of Changes that is mailed separately, not with the standard Welcome Kit.

B. Interrogatories – Program Specific Overview Requirements

B.1. Respondent shall provide samples and/or copies of the enrollment materials it will provide to Participants. Enrollment material samples submitted should be separate for the HealthSelect PDP and the HealthSelect Medicare Rx PDP). This response should include, but not be limited to, the items discussed in RFP Section V.A.13., which are as follows:

- An enrollment presentation to be written, recorded, and posted on the ERS website and delivered upon request at enrollment events;
- Letters to Participants, when applicable;
- Brochures explaining Program changes and updates;
- General Program information; and
- Enrollment information on PBM's website.

HealthSelect PDP:
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

HealthSelect Medicare Rx PDP:
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

B.2. Describe Respondent's ability to produce Participant-specific communications.

Express Scripts offers a portfolio of marketing materials to support the products and services offered by Express Scripts. If these materials do not meet all of ERS's needs, your dedicated communication specialist will work with our experienced communications teams to assist ERS in customizing your communication materials.

Our member materials are continuously improved to effectively communicate the prescription drug benefit. All of our member communication materials have been designed based on research and focus groups with current members. Our communications staff will work with ERS and your dedicated communications specialist to customize communications to reflect your unique requirements and plan design. Communication materials can be customized by our communications staff to highlight any important changes in the member's previous prescription drug plan. Research has shown that this type of effective communication increases member satisfaction.

B.2.a. Describe any limitations Respondent may have for producing customized communication materials for ERS. This should include, but not be limited to, any limitations Respondent may have in meeting deadlines for customized communications.

Express Scripts will work with ERS to provide mutually agreeable customizations to our member communications in agreed-upon timeframes. Limitations would include content that inaccurately represents Express Scripts' products or services or ability to provide them.

B.3. Describe Respondent's capabilities for staffing benefit fairs and other presentations and events, including webinars.

Express Scripts has reviewed ERS' benefit fair requirements as part of this RFP and will attend and provide staff as necessary. We also have the option to host digital benefit fairs, where we can create a digital benefit fair video to discuss topics including plan design, generics, our mobile app, and more. In addition to sending the video to members by email or posting on a company intranet site, we can also create a unique URL to share the video if needed.

With the lingering impacts of COVID-19, these virtual solutions are most invaluable. Other digital resources are available, including standalone videos and comprehensive, interactive fliers. We also expand virtual care through remote monitoring and private consultations with specialist pharmacists.

Finally, your account managers and account executives are extremely knowledgeable about your plan design to support you during the initial open enrollment and annually after that.

In addition to these services, we also offer ERS, an open enrollment website that provides access during open enrollment and year-round for new hires and existing members. This website will include general information about our company, a benefits overview for each of ERS's pharmacy benefit plan options, members' ability to locate an in-network pharmacy, and our price a medication functionality.

B.4. How will Respondent comply with the provision to assign a dedicated communication specialist to meet and work with ERS staff to produce communication materials?

Express Scripts agrees to provide ERS with a dedicated communication specialist to meet and work with your staff to produce your communication materials. This individual will be named upon contract award.

B.5. Respondent shall describe Respondent's methods for a Participant to access information about the Programs (i.e., mobile application, website, innovative methods, etc.)

Express-scripts.com is our digital touchpoint, along with the Express Scripts mobile app, that provides ERS's members with a personalized experience every time they log in. The member website's secure dashboard displays a variety of options, including easy to order medicine refills and renewals, order status, shipping details, and prescription and prior authorization expiration dates. The member website also allows the member to transfer eligible prescriptions to Express Scripts® Pharmacy. The many self-service features available enable members to accomplish multiple tasks quickly, such as paying a bill, verifying a shipping address, updating payment information, and managing preferences. The Express Scripts mobile app mirrors the member website in almost every way, providing a consistent experience regardless of the access point.

Members can easily navigate the member website to:

- View website most frequently used options upon first view – dashboard displays available refills, recent orders, and bill payment links
- Intuitive menu options to guide the member to the pages on the site they need
- Check order status and access tracking information
- Refill and renew prescriptions
- View the shopping cart and check out from any page
- Review important messages about managing their benefit and health
  Manage payment by storing multiple credit cards and checking accounts on file, as well as accessing PayPal and MasterPass
- Enter multiple addresses on file, including a temporary address, and verify the shipping address
- Select programs and make important benefit choices through decision flows that optimize health, pharmacy, and cost options (including home delivery, care value programs, and pharmacy networks)
- Set communications and viewing preferences from a helpful list of options, including "going green" by selecting email in favor of hard-copy communications, opting to receive Prescription, Account, Benefit & Safety Alerts via email or telephone, and sharing information with other household members
- Contact us at any time to get information, ask questions, and provide feedback, a key element in our approach to the continuous improvement of our member experience
- Submit claims for reimbursement, for non-Medicare members

Our online suite of prescription and pharmacy benefit tools, information, and services allow members to manage their benefit by potentially lowering costs, saving time, and staying on track with adherence reminders.

Members can also access helpful information about their specific pharmacy benefit plan, including:

- Benefit overview — This area features a summary of the pharmacy benefit provided by the patient's health plan and administered by Express Scripts. This at-a-glance overview provides plan benefit information such as days' supply, copayment, deductible, and out-of-pocket limits for home delivery and retail pharmacies.

- Find a pharmacy — Plan members can easily locate in-network participating retail pharmacies in and around a specific ZIP code or city/state. The website lists the closest participating pharmacies, as well as those pharmacies that will fill 90-day prescriptions. Finding a pharmacy is very convenient, as this page provides maps and links to driving directions.
- Forms and member ID cards — Members can print their member ID card and prescription history (to bring with them to their doctor) as well as download home delivery forms and retail claim forms. Members can also submit prescription claims for reimbursement online. Members can also complete the Health, Allergy and Medication Questionnaire on this page; once submitted, this form becomes part of the safety check performed for all new prescriptions.

Mobile App

As shown in the images below, our mobile app has numerous features that are easily and conveniently accessible from the home page and side menu, including:

- Refills and renewals — With just two clicks, members can quickly and easily refill and renew their home delivery prescriptions.
- Order status — Members can track their home delivery prescription orders. The order status feature displays order tracking information at each step, including when orders are received, in process, and shipped — all on a single page.
- Pay a bill – Members can pay an outstanding balance using their mobile, during checkout of an order or directly. Payment methods can be edited at checkout.
- Price a Medication — Find a medication's lowest price by comparing home delivery from Express Scripts® Pharmacy with up to 10 retail pharmacies, depending on plan set up, based on the member's current location or chosen ZIP code. If applicable, the app will denote ERS's preferred network pharmacies. Generic alternatives are also provided if available.
- Enroll in automatic refills — This convenient automatic refill program for ongoing medicines using Express Scripts' home delivery helps to reduce gaps in care caused by missed refills. Members can change their next refill date or disenroll at any time.
- Transfer to home delivery — Members can request home delivery for medications taken on an ongoing basis that are currently obtained from a retail pharmacy.
- Dose Reminders — This feature automatically syncs with the patient's current prescription drug history and provides patients with the ability to track all of their prescription medication dosing regimens, while allowing the patient or caregiver to create alerts on their phone to remind them when it is time to take their medication throughout the day. It also notifies members when they are running low on their medications.
- Claims and history — Members can review their past prescription activity and invoice details for up to a 24-month period. Claim information can be displayed for retail and home delivery prescriptions for the member and all eligible dependents.
- Find a pharmacy — Members can search for the nearest in-network retail pharmacies by their current location or by entering an address or ZIP code. The closest available pharmacies are displayed in a list and map view; pharmacies that will fill 90-day prescriptions are also identified. Members can view pharmacy contact information and get directions.

- Virtual member ID card — The virtual member ID card provides members with the convenience of simply pulling out their mobile device at the pharmacy instead of having to search through their wallet for their member ID card. Soon members will be able to store their member ID card in their Virtual Wallet.
  Express Scripts considers this response to be proprietary and confidential.

Mobile App for Medicare Beneficiaries

A complement to our clinical and consultative Star Ratings solutions, the Express Scripts mobile app is an effective way to help Medicare members easily stay on track with adherence, readily obtain their prescriptions, and enhance their drug benefit experience — all measured through the Centers for Medicare & Medicaid Services (CMS) Star Ratings program.

Through this easy-to-use, self-service app, our Medicare members instantly access their personalized medication information; refill and track Express Scripts® Pharmacy prescription orders; receive personalized gap-in-care and safety alerts when a member is late in ordering a refill for their maintenance medication, for example; and set reminders to stay on track with prescribed medications.

Express Scripts considers this response to be proprietary and confidential.

Pharmacy is the most widely used healthcare benefit — this means the most opportunities to provide positive member experiences. The Express Scripts mobile app is a key part of that experience because it lets members save time while better managing their prescription drug benefits.

Express Scripts mobile app users[1]are 19% less likely to experience a gap in care. One member stated that the best features of the app include "letting you know when you need refills or renewals and keeping track of the number of pills you have left. Definitely useful for me, as I am super forgetful!"

[1] These results reflect overall metrics for the Express Scripts mobile app — not specifically the app for Medicare members.

C. Interrogatories – Ongoing Communications Requirements

C.1. Respondent shall provide proposed samples of all required materials in RFP Section V.B.2., which includes the following:

- Brochures and newsletters;
- GBP-specific website;
- Presentations (enrollment, etc.);
- Participant communication and general information pieces;
- SE/FE communications;
- Consumer-targeted education materials;
- Standard messaging for various systems' downtime;
- Pharmacy directory, including specific disclaimer stating that the list of pharmacies is subject to change;
- Drug formulary, including specific disclaimer stating that the formulary is subject to change;
- All advertising materials in association with the Programs;
- Welcome packets, including Welcome Letter and Program Guide;
- Articles for ERS newsletters;
- Facebook posts for ERS' Facebook page;
- News updates for ERS website;
- *Ad hoc* publications;
- Publications listing with audience and publish target dates;
- Token giveaways for enrollment fairs and events; and
- Other related statements.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

Express Scripts has also included our standard communications portfolio as part of the requested submission.

C.2. Provide any sample communication materials Respondent may have on the following:
- Merits of generic substitution;
- Respondent's proposed formulary(ies) and/or preferred drug lists; and
- Medical conditions for which generic medications are available.

☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

Participant Notifications

C.3. Describe the process for HealthSelect PDP and HealthSelect Medicare Rx PDP (e.g., regular mail, email, newsletters, etc.) for notifying Participants of:
- Expiration date of their prescriptions;
- The next refill date and the remaining number of refill(s);
- Prescriptions not on formulary, include how Participants are notified of prescriptions not on the formulary;
- Generic substitution availability;
- Drug utilization management requirements, include if there is a point of sale messaging provided to pharmacies for drug utilization management requirements;
- Savings intervention opportunity messages;
- Prescription expirations at retail pharmacies; and
- COB messages.

HealthSelect PDP:

Refill reminders are provided to members to help ensure that they receive their prescriptions on time by reminding them when it's time to refill or renew. Members are also alerted when they are late to fill. Communications are sent 14 days prior to their drug runout date, 7 days prior to their drug runout, 2 days after drug run out, and 10 days after drug runout. Once a prescription is refilled or renewed, no additional communications are sent. Reminders are sent via mail, email, the member website, phone, text, and/or on the mobile app, as described below. The medication label also indicates the number of refills remaining.

Mail

As part of the Express Scripts® Pharmacy dispensing process, we provide refill notices with each prescription that indicate how many times the prescription may be refilled. Please note that as part of our "green" initiative, refill notices are not included in orders placed via phone, Interactive Voice Response Unit (IVRU), or the Internet, because that information is available at the time the order is placed. For example, members logged in to the member website can see which prescriptions are ready to be refilled immediately, which require the prescriber's authorization, and which can be pended to refill on the eligible date.

Online

When members register with express-scripts.com, they are automatically enrolled to receive refill reminders via email, unless they choose to opt out. Also, all members that provide an email address on an Express Scripts® Pharmacy order form receive email refill reminders. The email includes a convenient link to the member website that facilitates navigation to the online refill feature. Users also see additional messaging in the Order Center reminding them to refill medications for which our records show a possible gap in care. Members can choose to refill the medication in the way they have in the past, choose a one-time reminder email option, or indicate that they no longer need the medication.

Phone

We provide outbound voice messages to targeted members who are eligible to refill their medications. These messages are used for members who have exhibited patterns of not refilling medications on time in the past. Automated messages help promote compliance with prescription therapy. For members who regularly speak to a patient care advocate to request refills, we may place an outbound message to remind the member that they can refill the prescription through the website or through IVRU.

Text

Members who have opted into receiving text messages will receive interactive messages to refill or renew their medication.

Formulary Communications

Express Scripts supports a comprehensive communication strategy that informs members about formulary drugs and provides updates before the annual formulary changes.

Member Communications

- Introductory member packet — This first-line communication describes the formulary benefit, including member coinsurance and copayment responsibilities. The packet includes information on how we can assist the member in converting from a nonpreferred medication to a preferred brand or generic.
- Formulary notification letters — Express Scripts notifies members affected by a formulary change. We notify members for deletions and exclusions 30 days in advance.
- Express Scripts® Pharmacy prescription outreach — The outreach service is designed to educate members about their benefit and provide the opportunity to help them save money with generic or formulary medications. The service targets brand medications changing formulary status for conversion to therapeutically equivalent generics or formulary brands.
- Contact Center — Members can call Express Scripts for formulary-related questions or for a list of drug changes for the new year. Our patient care advocates and automated system answer client and member formulary questions by phone.
- Express Scripts pharmacy communications — Members receive additional reminders in the form of telephone messages and inserts with their refills before and after a formulary change is effective.
- Express Scripts' member website and mobile app — To enhance dialogue with physicians, members can view formulary drug information, including generic options.

Network Pharmacy Communications

Express Scripts will work with ERS to customize point-of-service messaging as needed. All customized messages must be in accordance with NCPDP regulations and are subject to Express Scripts' internal review process. ERS-specific custom messaging is implemented as quickly as possible to support coverage, dispensing policies, or client rules, depending on the complexity of the request. Should messaging be required outside of standard requests, development fees may apply.

HealthSelect Medicare Rx PDP:

No difference.

D. Interrogatories – Website Content Requirements

D.1. Respondent shall describe how it will ensure that it's customizable Program website will be functioning in accordance with RFP and Contract requirements.

During the initial phase of the implementation, your seasoned implementation team will gather the requirements necessary to ensure your website is functioning in accordance with what is laid out in the RFP and Contract. After gathering all the necessary information, your implementation team will engage internal teams from across our enterprise to set up your the website as intended. A robust project timeline will outline each task, and your implementation team will ensure project progress and keep ERS informed.

D.2. Respondent shall describe how it will ensure that Respondent's configurable claims website will be functioning in accordance with RFP and Contract requirements.

During the initial phase of the implementation, your seasoned implementation team will gather the requirements necessary to ensure your website is functioning in accordance with what is laid out in the RFP and Contract. After gathering all the necessary information, your implementation team will engage internal teams from across our enterprise to set up your the website as intended. A robust project timeline will outline each task, and your implementation team will ensure project progress and keep ERS informed.

D.3. Respondent shall submit a mocked-up "test" website as described in RFP Sections V.D.3. – V.D.3.a.
☐ Provided ☒ If unable to provide or if this is not applicable, check here and explain.

Express Scripts does not have a test website to share with ERS. Our website design team will work with you to assess your needs and create a user experience that will consistently delight your members. The client website will be available to onboard within the ERS network with full support of our technology teams at the time of implementation. While our security protocols do not allow dummy usernames or passwords, designated ERS staff may register in advance to access and test the website. We can provide ERS with a live demonstration of our wide range of member website and mobile app capabilities either in person or via web conference.

D.4. Provide a list of features that are available to Participants via Respondent's website.

Express-scripts.com is our digital touchpoint, along with the Express Scripts mobile app, that provides ERS's members with a personalized experience every time they log in. The member website's secure dashboard displays a variety of options, including easy to order medicine refills and renewals, order status, shipping details, and prescription and prior authorization expiration dates. The member website also allows the member to transfer eligible prescriptions to Express Scripts® Pharmacy. The many self-service features available enable members to accomplish multiple tasks quickly, such as paying a bill, verifying a shipping address, updating payment information, and managing preferences.

We recently introduced a modernized dashboard experience which is a responsive design whereas it is easily adaptable to any screen size — from computer screen to mobile device – eliminating the need for members to pinch and expand the screens on their mobile device. The redesigned dashboard will allow members to easily access frequently used features without scrolling. Indicators alert members to actionable items such as showing the number of prescriptions that are ready for refill. This helps members stay on track at a glance. Refilling or renewing a prescription is easier with just two clicks to add it to the cart.

Our online suite of prescription and pharmacy benefit tools, information, and services allow members to manage their benefit by potentially lowering costs, saving time, and staying on track with adherence reminders. The member experience is continually enhanced to provide simple, self-service tools, including the ability to:

- Check order status — A snapshot view into order status is found by one click on the dashboard page – providing the member with a quick view into relevant details including: the status of the order, drug name and Rx number, estimated ship dates, delivery tracking number linked to real-time delivery information. A full list of all order-related information is available on an additional page, including prior authorization expiration date, physician's name and address, and prescription expiration dates.
- Refill and renew prescriptions, and take advantage of convenient refill reminders — One click adds a refill to the shopping cart. When renewals are needed, a member can obtain a new prescription or Express Scripts can contact the member's provider on their behalf.
- Review pharmacy options — Members can review their potential savings by switching their maintenance prescriptions to either Express Scripts® Pharmacy or a 90-day retail pharmacy. The member is presented with pharmacies to choose from, enabling them to make a decision based on cost savings and convenience. The member can select all medications or just those medicines they would like to transfer. By choosing home delivery, the member gives us permission to reach out to their doctor on their behalf to request a 90-day supply prescription. This feature provides members with access to Express Scripts pharmacists from the privacy of their home.
- Order prescriptions for other household members — When authorized by the appropriate household member, plan members are able to view prescription history and place orders for other covered household members.
- Order prescriptions for patients who have Express Scripts coverage under different member ID numbers with different benefits with one user name and password.
- Review claims, balances, and annual prescription expenses — The claims and balances area allows members to track their out-of-pocket prescription expenses by month or by year for a 24-month period, as well as obtain detailed account information, such as their current balance and invoice details. This information helps members in compiling prescription costs at tax time, as well as for submission to flexible spending account administrators. Records are maintained for retail and home delivery prescriptions for the member and all eligible dependents. Prescription details, including when the medication was last filled, number of refills remaining, and associated medication information, are easily accessible. Members can download their claims into Excel for more flexibility in the use of this valuable information.
- View Prior Authorization status — including: Case ID, medication name and quantity, requested status, the step in which the PA is in process, and the ability to expand and view details on each case.
- Members can also submit prescription claims for reimbursement online.
- Enroll in automatic refills — This convenient automatic refill program for ongoing medicines using Express Scripts' home delivery helps to reduce gaps in care caused by missed refills. Members can change their next refill date or disenroll at any time.
- Consumer-directed health (CDH) plans — For clients that offer CDH plans, the website features information to help members track their healthcare spending accounts, deductibles, and out-of-pocket expenses, including starting balances and amounts applied to and remaining for their specific plan options. Express Scripts has also added a new Interactive Web Chat (IWC) to assist clients with educating members on their CDH pharmacy plan.

- Price a medication — Compare medication pricing and coverage information for both brand name and generic medications at home delivery or through a 30-day or 90-day retail pharmacy, based on the members' specific prescription benefit plan guidelines. This convenient tool, using usual and customary pricing in its prospective retail pricing calculations, also helps educate members about the cost savings afforded by switching to generics, as well as plan-preferred medicines (preferred alternatives), or transferring to home delivery. Members can select up to three pharmacies to view costs at these locations. Price a medication is especially helpful for members with CDH plans and other high-deductible plans because it helps members manage their out-of-pocket expenses.
- View drug information — The website provides medicine information, including pictures, side effects, and drug interactions.
- Checkout from any page — Medicines added to the shopping cart throughout the member's online session can be checked out at any time. The cart clearly indicates which medicine is being purchased, as well as which medicines are eligible for refill but are not in the cart, thereby assuring that needed medicines are not forgotten. A simple checkout process confirms shipping method (standard, one-day, or two-day); payment method, which can be updated at any point; and final order review. Members can change their shipping method at any time before the medication actually ships.
- Manage payment methods — We offer payment flexibility to enable members to manage their finances as well as their medicines. For example, through autopay, which allows a member to automatically pay for orders, the member can pay with a credit card, debit card, checking account, MasterPass (a digital wallet), or PayPal by selecting the applicable method of payment during checkout; or the member can request to be billed later. The member can store multiple payment methods and then choose between them at checkout. Members can also manage their payment authorization limit, which is especially convenient for those managing multiple or expensive orders.

Members can also access helpful information about their specific pharmacy benefit plan, including:

- Benefit overview — This area features a summary of the pharmacy benefit provided by the patient's health plan and administered by Express Scripts. This at-a-glance overview provides plan benefit information such as days' supply, copayment, deductible, and out-of-pocket limits for home delivery and retail pharmacies.
- Forms and member ID cards — Members can print their member ID card and prescription history (to bring with them to their doctor) as well as download home delivery forms and retail claim forms. Members can also submit prescription claims for reimbursement online. Members can also complete the Health, Allergy and Medication Questionnaire on this page; once submitted, this form becomes part of the safety check performed for all new prescriptions.
- Find a pharmacy — Plan members can easily locate in-network participating retail pharmacies in and around a specific ZIP code or city/state. The website lists the closest participating pharmacies, as well as those pharmacies that will fill 90-day prescriptions. Additional information includes: indicator of pharmacies dispensing vaccines and compounds, filter criteria specific to member needs and according to their benefit design (e.g., needs: vaccine, compound, plan-recommended). Finding a pharmacy is very convenient, as this page provides maps and links to driving directions.

We understand the value of online engagement and encourage members to take full advantage of our digital tools. According to ongoing reviews of our own data, we find that members who use digital channels are less likely to have a gap in care. Adherence is an important part of maintaining health, and member registration is a helpful tool to remaining adherent.

Members can register via the member website or through the mobile app. In addition, to ensure an optimal member experience, Express Scripts' patient care advocates are available via phone to help register members on express-scripts.com. Upon registering, advocates initiate an auto-email with an embedded secure token to the member. Members can then easily and immediately complete the registration process — with just one click.

First-time visitors to the website register by creating an online account by providing their member ID number or social security number and then choosing a username and password. The member can use the same username and password to access the mobile app. In cases where a member forgets the login information, a simple account recovery process allows the member to reset the information quickly and easily. A screenshot of our member website log in page, express-scripts.com, is below.

Express Scripts considers this response to be proprietary and confidential.

The dashboard style home page allows first-time visitors to learn more about their prescription benefit options and enables returning members to quickly navigate to the actions they use most (i.e., check available refills, recent order status, or pay a bill using single-click buttons.) Customized messages appear in the right hand side of the screen as applicable by client plan design and specific programs in which a member participates. After a member registers or logs in, the personalized member website homepage appears, providing the most requested information, including recent order status and prescriptions eligible for refill and renewal, at the top of the page, as shown in the screenshot below:

Express Scripts considers this response to be proprietary and confidential.

D.5. Does Respondent have an on-demand cost-estimator tool that allows a Participant to see their personal savings associated with changing medications from brand to generic, network pharmacy to non-network pharmacy, and/or from retail to mail service/EDS?

HealthSelect PDP:

Yes, with the exception of non-network pharmacy savings. Price a Medication is an online resource, using the member's specific prescription benefit plan guidelines, that members can use to find pricing and coverage information for both brand name and generic medications through Express Scripts® Pharmacy and a retail pharmacy for side-by-side comparison. For example, the tool allows the member to compare Express Scripts® Pharmacy to a retail pharmacy, or one retail pharmacy versus another retail pharmacy. This convenient tool helps educate plan members about the cost savings afforded by generics and preferred brands.

Additionally, Price a Medication provides usual and customary (U&C) prices to members, as appropriate. For members who have plans with accumulators, such as a deductible or other caps, pricing results will take their current balances into account. Drug information is provided for each medication searched.

HealthSelect Medicare Rx PDP:

Yes, with the exception of non-network pharmacy savings. Price a Medication is an online resource, using the member's specific prescription benefit plan guidelines, that members can use to find pricing and coverage information for both brand name and generic medications through Express Scripts® Pharmacy and a retail pharmacy for side-by-side comparison. For example, the tool allows the member to compare Express Scripts® Pharmacy to a retail pharmacy, or one retail pharmacy versus another retail pharmacy. This convenient tool helps educate plan members about the cost savings afforded by generics and preferred brands.

Additionally, Price a Medication provides usual and customary (U&C) prices to members, as appropriate. For members who have plans with accumulators, such as a deductible or other caps, pricing results will take their current balances into account. Drug information is provided for each medication searched.

D.5.a. If so, can this function use existing claim history, ERS PDP-specific Program design and pricing when estimating costs?
HealthSelect PDP:

Confirmed with the exception of claims history.

HealthSelect Medicare Rx PDP:

Confirmed with the exception of claims history.

D.6. Across its book of business, what percentage of Respondent's employer-sponsored plan employee's register on Respondent's authenticated member portal?
Commercial PDPs:

23.6%

Medicare Part D EGWP + Wrap PDPs:

46.57%

D.7. Respondent shall describe its experience and capabilities in establishing a Participant support phone line and client-specific open enrollment website ahead of ERS' open enrollment. This functionality would include, but not be limited to, the ability to price individual prescriptions, determine drug coverage, formulary status, alternatives and pharmacy locator.

Express Scripts can support your open enrollment as long as we have received new or updated plan designs by the mutually agreed upon date. Members will have access to our patient care advocates 24 hours a day, seven days a week. Advocates can access and provide your members with the following information:

- Participating retail pharmacy locations
- Drug-specific coverage
- Drug-specific copayment
- Instructions on how to begin home delivery

ERS is responsible for distributing member communication materials containing the toll-free customer service number along with an accurate description of new plan design or plan changes. Benefit designs need to be finalized by Express Scripts and ERS by the agreed upon implementation timeframe. Benefit Operations will need to have all the client benefit information in order to build Open Enrollment Groups. After ERS supplies Express Scripts with the appropriate plan information, we enter it into our system to make available for our patient care advocates to reference.

Open Enrollment Website

ERS can elect to have open enrollment support available to your members via our open enrollment website. Recently updated and streamlined, you can add your logo, as well as customize some site content and provide PDF documents for members to download. If ERS offers more than one plan design for a given plan year, a selection page will open from the Open Enrollment section of the homepage, providing access to all available plans. The next year and all subsequent years, ERS can display available plan designs for both the current and upcoming plan year, for those employees hired during the open enrollment season.

In addition, this serves as a simple introduction to Express Scripts, allowing members to view detailed portions of our website and their plans, but without creating a log-in or profile.

The open enrollment website provides both current and potential members with the opportunity to learn more about their pharmacy benefit or changes to their pharmacy benefit prior to their effective date. It allows members to access basic information about key pharmacy-related open enrollment items, including:

- Reviewing pharmacy benefit plan highlights
- Comparing prescription medication costs, including formulary and coverage information
- Finding a convenient in-network pharmacy

Our online pricing tool allows members to make more informed decisions by easily comparing current therapy costs to the costs of therapeutic equivalents or alternatives, if available. This information helps members understand potential lower-cost alternatives before their pharmacy benefit begins.

D.8. **Mobile Application.** Respondent shall describe the mobile device capabilities and functionality that shall be available to ERS Participants.

The Express Scripts mobile app mirrors the member website in almost every way, providing a consistent experience regardless of the access point. Our mobile app has numerous features that are easily and conveniently accessible from the home page and side menu, including:

- Refills and renewals — With just two clicks, members can quickly and easily refill and renew their home delivery prescriptions.
- Order status — Members can track their home delivery prescription orders. The order status feature displays order tracking information at each step, including when orders are received, in process, and shipped — all on a single page.
- Pay a bill – Members can pay an outstanding balance using their mobile, during checkout of an order or directly. Payment methods can be edited at checkout.
- Price a Medication — Find a medication's lowest price by comparing home delivery from Express Scripts® Pharmacy with up to 10 retail pharmacies, depending on plan set up, based on the member's current location or chosen ZIP code. If applicable, the app will denote ERS's preferred network pharmacies. Generic alternatives are also provided if available.
- Enroll in automatic refills — This convenient automatic refill program for ongoing medicines using Express Scripts' home delivery helps to reduce gaps in care caused by missed refills. Members can change their next refill date or disenroll at any time.
- Transfer to home delivery — Members can request home delivery for medications taken on an ongoing basis that are currently obtained from a retail pharmacy.
- Dose Reminders — This feature automatically syncs with the patient's current prescription drug history and provides patients with the ability to track all of their prescription medication dosing regimens, while allowing the patient or caregiver to create alerts on their phone to remind them when it is time to take their medication throughout the day. It also notifies members when they are running low on their medications.
- Claims and history — Members can review their past prescription activity and invoice details for up to a 24-month period. Claim information can be displayed for retail and home delivery prescriptions for the member and all eligible dependents.

- Find a pharmacy — Members can search for the nearest in-network retail pharmacies by their current location or by entering an address or ZIP code. The closest available pharmacies are displayed in a list and map view; pharmacies that will fill 90-day prescriptions are also identified. Members can view pharmacy contact information and get directions.
- Virtual member ID card — The virtual member ID card provides members with the convenience of simply pulling out their mobile device at the pharmacy instead of having to search through their wallet for their member ID card. Soon members will be able to store their member ID card in their Virtual Wallet.

E. Interrogatories – Website Specifications Requirements

Respondent shall maintain internet websites for the HealthSelect PDP and HealthSelect Medicare Rx PDP.

E.1. If Respondent currently maintains an internet website, provide the URL address.

Our member website is www.express-scripts.com.

E.2. Is Respondent Section 508 and WCAG 2.0 compliant? ☒ Yes ☐ No

E.2.a. If the answer to the preceding question is "yes," Respondent shall provide a report from an independent provider evidencing Respondent's Section 508 and WCAG 2.0 compliance. Note: If Respondent cannot provide a report from an independent provider, Respondent shall provide results of an evaluation method Respondent used to validate compliance with Section 508 and WCAG 2.0 (i.e., results of website checkers or scans).
☒ Provided ☐ If unable to provide or if this is not applicable, check here and explain.

E.2.b. If Respondent is not currently Section 508 and WCAG 2.0 compliant, Respondent shall describe Respondent's timeline and remediation plans for when it will implement these requirements.

Not applicable.

CLIENT LOGO HERE

CLIENT OR TPA
ATTN: HUMAN RESOURCES
ADDRESS
CITY, AA 12345
SMPL INT_CARDS

EXPRESS SCRIPTS®

CHAMPIONS FOR BETTER℠

EXPRESS SCRIPTS®

CLIENT LOGO HERE

Prescription ID Card

RxBIN	**003858**	**Issued XX/XX/XXXX**
RxPCN	**A4**	
RxGrp	**Default**	
Issuer (80840)	**9151014609**	
ID	**CWK000100002**	
Name	**JOHN Q SAMPLE**	

EXPRESS SCRIPTS®

CLIENT LOGO HERE

Prescription ID Card

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Issuer (80840)	**9151014609**	
ID	**CWK000100002**	
Name	**JOHN Q SAMPLE**	

0999999000001010O

2022999999 - 000000001 CID PMM-CWK

JOHN Q SAMPLE
123 ANYSTREET
APT. 456
SOMETOWN, US 99999-9999

Here are your new ID cards.

ALWAYS HERE TO HELP!

Welcome to Express Scripts! As your Champions for Better℠, we're here to give you better, simpler ways to manage your prescriptions and your health. Here are a few highlights Client Name or TPA employees can expect starting May 1, 2022:

Easy
Register online or download the Express Scripts® mobile app to have your info with you at all times and check coverage, medication price and generic availability.

Accessible
Connect with pharmacists in the app, or online and by phone 24/7.

Personalized
Communication options so you can control how you hear from us.

Convenient
Order refills, track shipments, compare prices and access your plan info – all online.[1]

1. First-time visitors must register using their member ID number or Social Security Number. You can manage your medicine online when your coverage takes effect. Before then, you can set up your online account, including your preferred shipping address, preferences, and payment method(s) for home delivery orders.
2. Automated text message will be sent to you. Message and data rates apply. Not a condition of purchase.

Helpful Tips:

- To price a medication, choose "Price a Medication" from the Prescriptions menu, enter your drug name and click Search. After you find your medication, you will be able to view cost and coverage information.
- Whether you are viewing the member website or using the Express Scripts® mobile app, you can easily manage your home delivery prescriptions[1]:
  - Get started by contacting your doctor to request a three-month prescription that he or she can e-prescribe directly to Express Scripts Home Delivery.
  - Or print a form by selecting Forms from the menu under Benefits. Print a home delivery order form and follow the mailing instructions.
  - Or call us and we'll contact your doctor for you.

Please allow 10 to 14 days for your first prescription order to be shipped.

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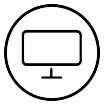
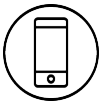
2WCNRT01.LTR

3 easy ways to set up your account and get started:



Visit express-scripts.com

Visit your favorite app store to download the Express Scripts® mobile app



Text JOIN to 69717 for a link to our registration page[2]

Express Scripts Customer Service:	**800-711-0917**
Accredo Specialty:	**800-803-2523**
TDD:	**800-759-1089**
Pharmacist Use Only:	**800-922-1557**
express-scripts.com	accredo.com

Express Scripts Customer Service:	**800-711-0917**
Accredo Specialty:	**800-803-2523**
TDD:	**800-759-1089**
Pharmacist Use Only:	**800-922-1557**
express-scripts.com	accredo.com

WE'RE YOUR CHAMPIONS FOR BETTER℠

Pay less, relax more and skip the trip with home delivery.

Get long-term medication (and savings) delivered right to your door from Express Scripts.

- Up to a three-month supply for just one copay
- Free standard shipping[1]
- Refill online, by phone and with our app
- Sign up for automatic refills and we'll send your medication to you when it's time to refill

Get personalized care from our specialty pharmacy.

You'll use Accredo to fill specialty medications that treat complex conditions like multiple sclerosis, hepatitis C and cancer. Through Accredo, you'll have 24/7 access to specialty-trained pharmacists and nurses who understand your condition. Call us at 800-803-2523 to get started.

Choose from a variety of retail pharmacies.

- Place orders in person, at the pharmacy or over the phone
- Pick up your prescription at a participating network retail pharmacy
- You may need to fill long-term medications with home delivery, but you can always fill your acute prescriptions at retail

Preferred Medications.

Your plan has a list of generic and brand-name drugs that are preferred. The list may change and some preferred medications may become nonpreferred, some may become preferred and some may no longer be covered. Here's the difference:

- Preferred (or formulary) drugs cost less than nonpreferred. This list of medications is determined based on the advice of pharmacists and a group of independent doctors. (It's applicable to many clients serviced by Express Scripts.)
- Nonpreferred (or nonformulary) drugs may cost you more.
- Noncovered (or excluded) drugs aren't covered under the plan. You can log in at express-scripts.com to see any Formulary Exclusions that apply to your plan.

[1]Standard shipping costs are included as part of your prescription plan.

Seq. #: 000-000-001
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2STDRT01.CDS

EGWP Member Communications

CMS Compliant, Implementation Ready

- EGWP member materials are comprehensive and retiree-friendly. Many of our communications are based on CMS model documents– ensuring clear, compliant messages delivered in an easily-understood format. Our materials are ready for implementation and require minimal versioning.

- Prior to your implementation date, we begin communicating with all of your targeted members to ensure they are aware of, and educated on, their upcoming plan change.

- On the following pages you'll find samples of the communications your members may receive:

EGWP Communication Strategy

We recommend a multi-pronged communications approach, combining both client communications and Express Scripts communications.

Introduction	• Banner messaging on client-sponsored website • Retiree Customer Service phone IVRU/hold time messaging • Utilize client-sponsored newsletter to provide retirees an introduction to the EGWP
Education	• Express Scripts opt-out mailing containing key benefit information and other information regarding the EGWP • Client and Express Scripts Customer Service scripting /Q and A's
Ongoing Communications	• Member ID card and Welcome Kit mailing • Enrollment/Disenrollment Letters • Ongoing communications via the client-sponsored website; Express Scripts can provide content and messaging as needed

Member Communications Experience

We deliver the following critical messages to ensure members have a clear understanding of upcoming plan changes and any required actions that must be taken.

IMPLEMENTATION

- **Prenotification**
  - Prenotification letter
  - Benefit Overview
- **Welcome Kit Package**
  - Member ID card/Welcome Letter
  - Benefit Overview
  - Quick Reference Guide (QRG)
  - Pharmacy/Formulary/Evidence of Coverage (EOC) Locator Notice
- **Extra Help Rider**
- **Late Enrollment Penalty (LEP)**
  - Notification of CMS identified members with lapse in coverage
  - Attestation form
  - Confirmation of LEP amount (if applicable)
  - Reconsideration request form

Pharmacy Directory, Formulary and EOC available by member request and online

ONGOING

- Late Enrollment Penalty (LEP)
- Enrollment/ Disenrollment
- Explanation of Benefits (EOB)
- Direct Claims
- Coverage Determination
- Grievance/ Appeals
- Coordination of Benefits (COB)
- Member Recovery
- Pharmacy Termination
- Transition Supply
- Formulary Notifications
- Excluded Provider, Pharmacy, Mfg
- Medication Therapy Management
- Precluded Provider

RENEWAL

- **Renewal Package**
  - Annual Notice of Changes (ANOC)
  - Quick Reference Guide (QRG)
  - Pharmacy/Formulary/Evidence of Coverage (EOC) Locator Notice
- **Extra Help Rider**

Pharmacy Directory, Formulary and EOC available by member request and online

Implementation Communications (Pre-enrollment)

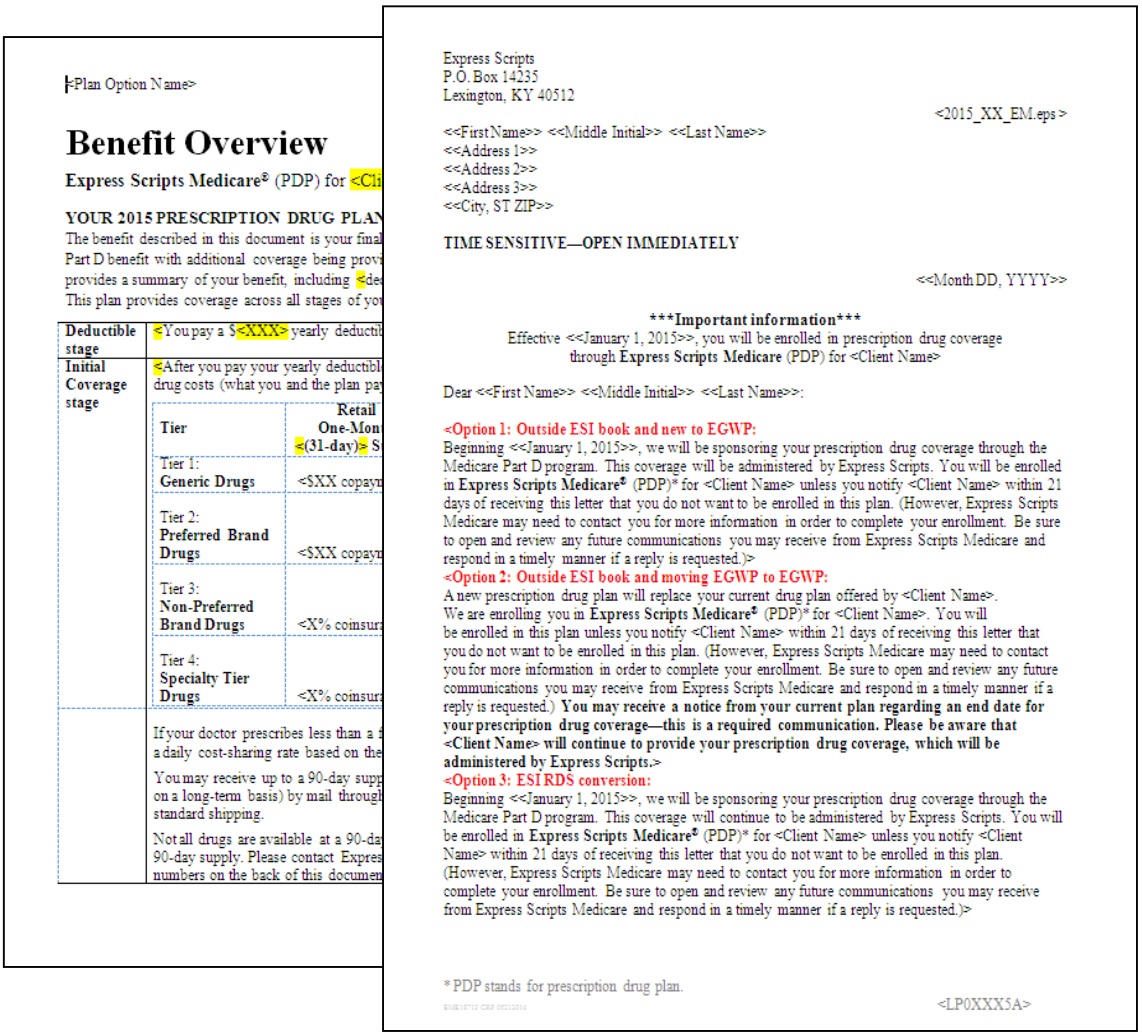
Implementation Communications

CMS requires the following member communications to be in a member's hands prior to the member's effective date in the plan.

Mailing	Objective	CMS Requirement	Plan Sponsor Responsibility	Express Scripts Support
Pre-notification	• Notifies members they will be group enrolled into the EGWP • Advises of ability to opt out	• Must be received by members at least 21 days before the plan's effective date per CMS guidelines	• N/A	• Pre-notification letter • Benefit Overview
Welcome Kit Package	• Provides confirmation of enrollment, Member ID card, and plan documents	• Must be mailed within 10 days of CMS approval of the member's enrollment	• N/A	• Creation and mailing of Welcome Kit
Extra Help Rider	• Provide low-income subsidy eligible members a summary of costs as a result of "Extra Help"	• Mailed upon enrollment and within 30 days of identification of change in low-income subsidy status	• N/A	• Creation and mailing of rider as needed
Late Enrollment Penalty	• Notifies members of the identification of a lapse in coverage, potential LEP penalty, confirms LEP penalty	• Letters must be sent within CMS-defined time frames for each letter (varies from 10-20 days)	• Make decision on attesting to member coverage and/or absorbing penalty	• Creation and mailing of letters

Implementation Communications: Prenotification Letter

Contains a letter and Benefit Overview that informs members of their enrollment into the plan, the time frame to opt out, and other benefit information.



<Plan Option Name>

Benefit Overview

Express Scripts Medicare® (PDP) for <Cli

YOUR 2015 PRESCRIPTION DRUG PLAN

The benefit described in this document is your final
Part D benefit with additional coverage being provi
provides a summary of your benefit, including <de
This plan provides coverage across all stages of yo

Deductible stage	<You pay a $<XXX> yearly deductib
Initial Coverage stage	<After you pay your yearly deductibl drug costs (what you and the plan pay

Tier	Retail One-Mon <(31-day)> S
Tier 1: **Generic Drugs**	<$XX copayr
Tier 2: **Preferred Brand Drugs**	<$XX copayr
Tier 3: **Non-Preferred Brand Drugs**	<X% coinsur
Tier 4: **Specialty Tier Drugs**	<X% coinsur

If your doctor prescribes less than a f
a daily cost-sharing rate based on the

You may receive up to a 90-day supp
on a long-term basis) by mail through
standard shipping.

Not all drugs are available at a 90-da
90-day supply. Please contact Expres
numbers on the back of this documen

Express Scripts
P.O. Box 14235
Lexington, KY 40512

<2015_XX_EM.eps >

<<First Name>> <<Middle Initial>> <<Last Name>>
<<Address 1>>
<<Address 2>>
<<Address 3>>
<<City, ST ZIP>>

TIME SENSITIVE—OPEN IMMEDIATELY

<<Month DD, YYYY>>

*****Important information*****
Effective <<January 1, 2015>>, you will be enrolled in prescription drug coverage through **Express Scripts Medicare** (PDP) for <Client Name>

Dear <<First Name>> <<Middle Initial>> <<Last Name>>:

<Option 1: Outside ESI book and new to EGWP:
Beginning <<January 1, 2015>>, we will be sponsoring your prescription drug coverage through the Medicare Part D program. This coverage will be administered by Express Scripts. You will be enrolled in **Express Scripts Medicare®** (PDP)* for <Client Name> unless you notify <Client Name> within 21 days of receiving this letter that you do not want to be enrolled in this plan. (However, Express Scripts Medicare may need to contact you for more information in order to complete your enrollment. Be sure to open and review any future communications you may receive from Express Scripts Medicare and respond in a timely manner if a reply is requested.)>
<Option 2: Outside ESI book and moving EGWP to EGWP:
A new prescription drug plan will replace your current drug plan offered by <Client Name>.
We are enrolling you in **Express Scripts Medicare®** (PDP)* for <Client Name>. You will be enrolled in this plan unless you notify <Client Name> within 21 days of receiving this letter that you do not want to be enrolled in this plan. (However, Express Scripts Medicare may need to contact you for more information in order to complete your enrollment. Be sure to open and review any future communications you may receive from Express Scripts Medicare and respond in a timely manner if a reply is requested.) **You may receive a notice from your current plan regarding an end date for your prescription drug coverage—this is a required communication. Please be aware that <Client Name> will continue to provide your prescription drug coverage, which will be administered by Express Scripts.**>
<Option 3: ESI RDS conversion:
Beginning <<January 1, 2015>>, we will be sponsoring your prescription drug coverage through the Medicare Part D program. This coverage will continue to be administered by Express Scripts. You will be enrolled in **Express Scripts Medicare®** (PDP)* for <Client Name> unless you notify <Client Name> within 21 days of receiving this letter that you do not want to be enrolled in this plan. (However, Express Scripts Medicare may need to contact you for more information in order to complete your enrollment. Be sure to open and review any future communications you may receive from Express Scripts Medicare and respond in a timely manner if a reply is requested.)>

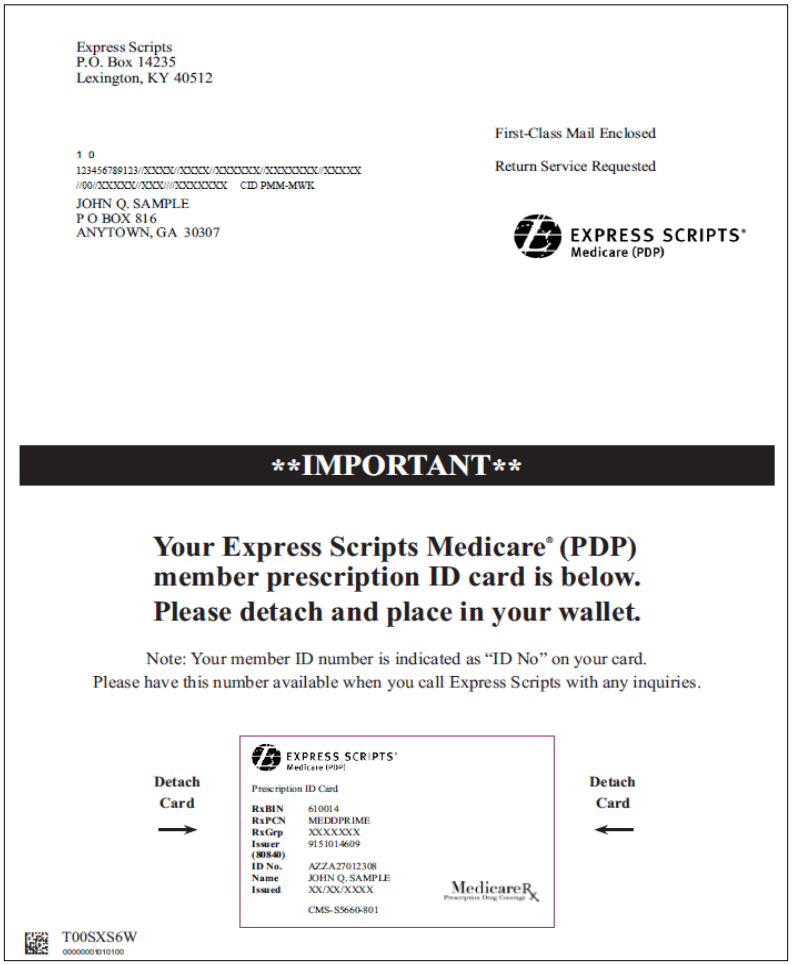
* PDP stands for prescription drug plan.

<LP0XXX5A>

When	Must be received by members a minimum of 21 days prior to effective date
Audience	Client-identified Medicare retirees
Client Logo	Yes

Implementation & Renewal: Welcome Kit Package

Provides new enrollees with Member ID cards and key benefit information.



Express Scripts
P.O. Box 14235
Lexington, KY 40512

First-Class Mail Enclosed

Return Service Requested

1 0
12345678912 3/XXXX//XXXX//XXXXXX//XXXXXXX//XXXXX
//00//XXXXX//XXX////XXXXXXX CID PMM-MWK
JOHN Q. SAMPLE
P O BOX 816
ANYTOWN, GA 30307

EXPRESS SCRIPTS®
Medicare (PDP)

****IMPORTANT****

Your Express Scripts Medicare® (PDP) member prescription ID card is below. Please detach and place in your wallet.

Note: Your member ID number is indicated as "ID No" on your card.
Please have this number available when you call Express Scripts with any inquiries.

Detach Card →

EXPRESS SCRIPTS®
Medicare (PDP)
Prescription ID Card
RxBIN 610014
RxPCN MEDDPRIME
RxGrp XXXXXXX
Issuer (903840) 9151014609
ID No. AZZA7012308
Name JOHN Q. SAMPLE
Issued XX/XX/XXXX
CMS-S5660-801
MedicareRx

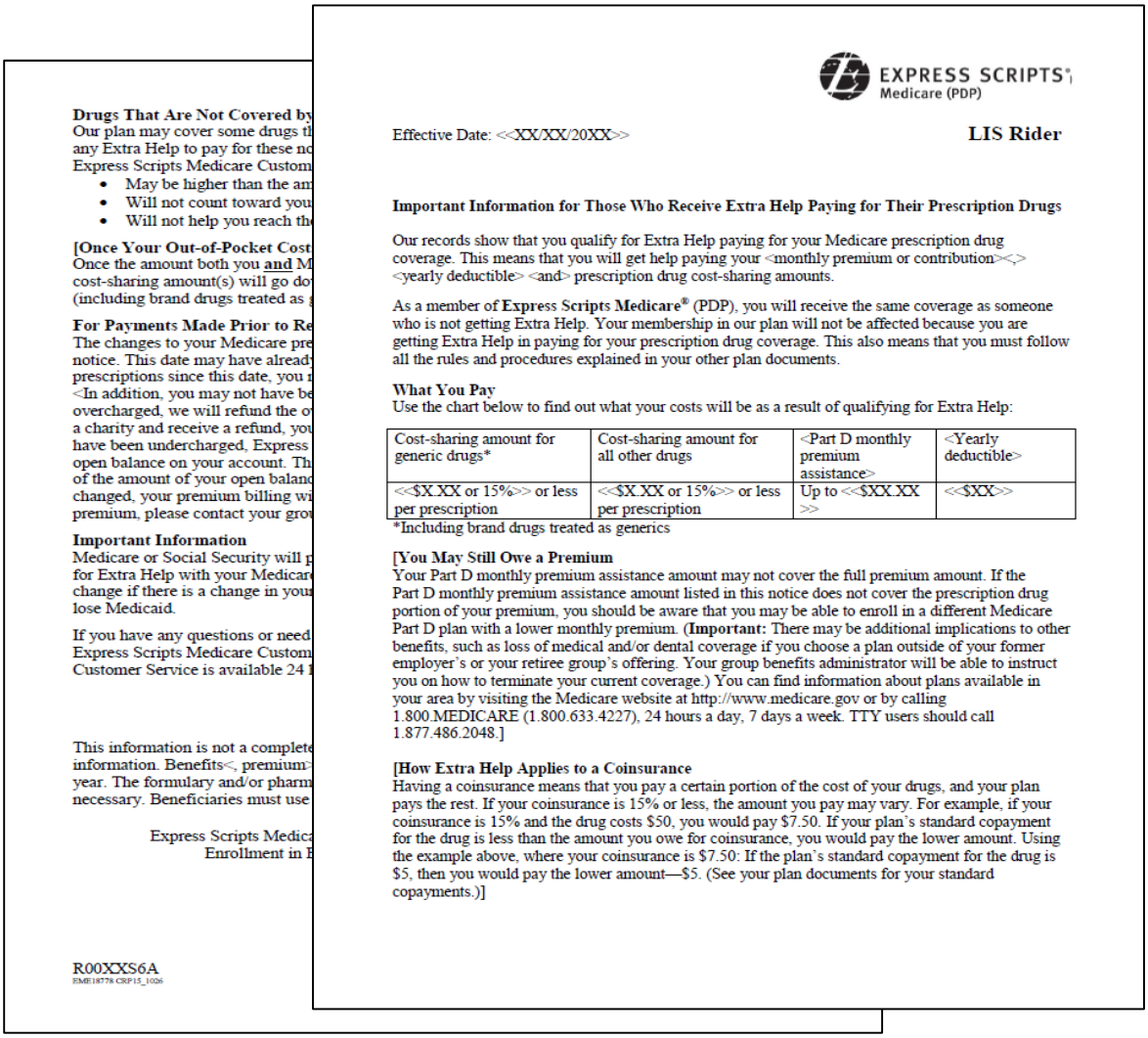
← Detach Card

T00SXS6W
00000001010100

When	Within 10 calendar days of receipt of CMS enrollment confirmation
Audience	All members identified by CMS as approved
Client Logo	Yes

Implementation & Renewal: Extra Help Rider

The Extra Help Rider is sent to members who qualify to receive a low-income subsidy, and explains premium assistance and copayments/coinsurance.



EXPRESS SCRIPTS® Medicare (PDP)

Effective Date: <<XX/XX/20XX>>

LIS Rider

Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs

Our records show that you qualify for Extra Help paying for your Medicare prescription drug coverage. This means that you will get help paying your <monthly premium or contribution><,> <yearly deductible> <and> prescription drug cost-sharing amounts.

As a member of **Express Scripts Medicare®** (PDP), you will receive the same coverage as someone who is not getting Extra Help. Your membership in our plan will not be affected because you are getting Extra Help in paying for your prescription drug coverage. This also means that you must follow all the rules and procedures explained in your other plan documents.

What You Pay
Use the chart below to find out what your costs will be as a result of qualifying for Extra Help:

Cost-sharing amount for generic drugs*	Cost-sharing amount for all other drugs	<Part D monthly premium assistance>	<Yearly deductible>
<<$X.XX or 15%>> or less per prescription	<<$X.XX or 15%>> or less per prescription	Up to <<$XX.XX >>	<<$XX>>

*Including brand drugs treated as generics

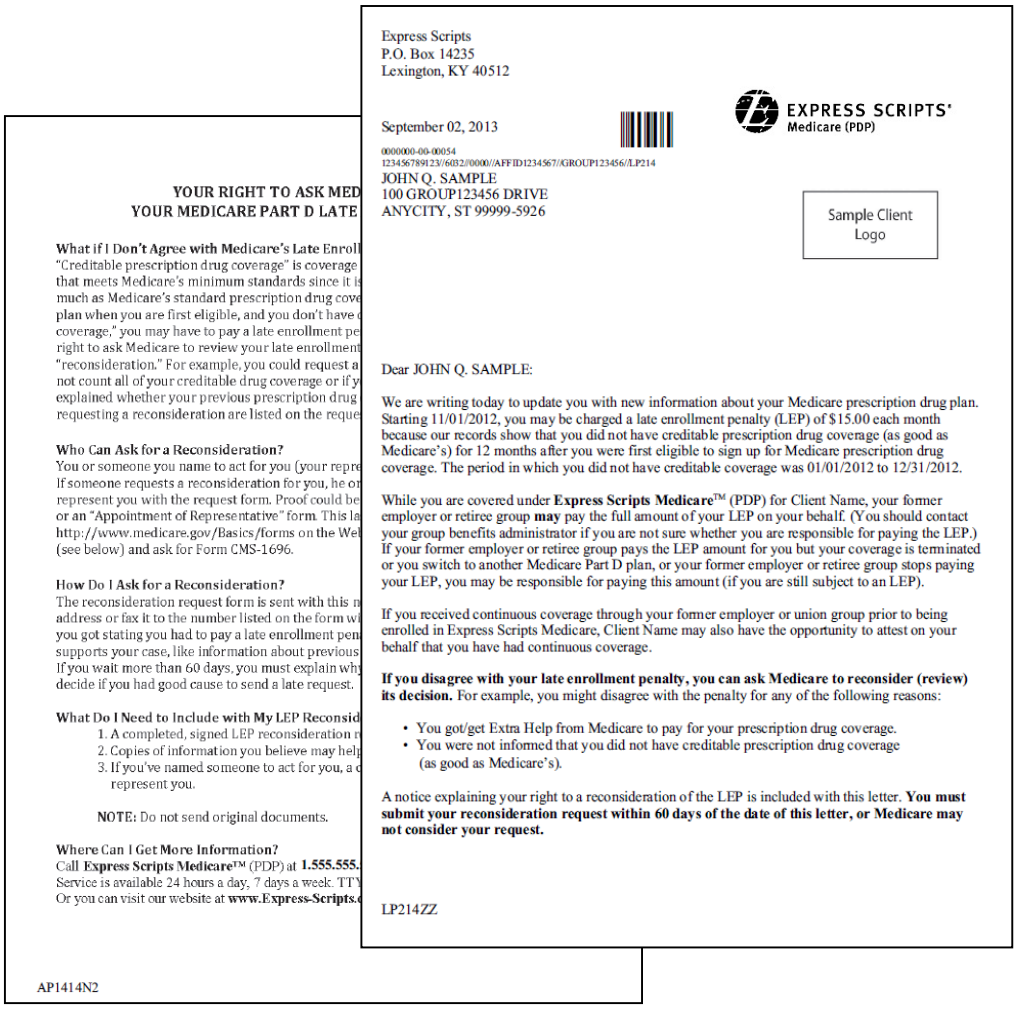
[You May Still Owe a Premium
Your Part D monthly premium assistance amount may not cover the full premium amount. If the Part D monthly premium assistance amount listed in this notice does not cover the prescription drug portion of your premium, you should be aware that you may be able to enroll in a different Medicare Part D plan with a lower monthly premium. **(Important:** There may be additional implications to other benefits, such as loss of medical and/or dental coverage if you choose a plan outside of your former employer's or your retiree group's offering. Your group benefits administrator will be able to instruct you on how to terminate your current coverage.) You can find information about plans available in your area by visiting the Medicare website at http://www.medicare.gov or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.]

[How Extra Help Applies to a Coinsurance
Having a coinsurance means that you pay a certain portion of the cost of your drugs, and your plan pays the rest. If your coinsurance is 15% or less, the amount you pay may vary. For example, if your coinsurance is 15% and the drug costs $50, you would pay $7.50. If your plan's standard copayment for the drug is less than the amount you owe for coinsurance, you would pay the lower amount. Using the example above, where your coinsurance is $7.50: If the plan's standard copayment for the drug is $5, then you would pay the lower amount—$5. (See your plan documents for your standard copayments.)]

When	Sent when a member is identified by CMS as qualified to receive a low-income subsidy or within 30 days of any LIS level changes
Audience	Members who qualify for a low-income subsidy

Implementation Communications: Late Enrollment Penalty (LEP)

Sent to members assessed with an LEP and informs them of the penalty amount. Clients may choose to pay the LEP on behalf of the member.



YOUR RIGHT TO ASK MED
YOUR MEDICARE PART D LATE

What if I Don't Agree with Medicare's Late Enroll
"Creditable prescription drug coverage" is coverage
that meets Medicare's minimum standards since it is
much as Medicare's standard prescription drug cove
plan when you are first eligible, and you don't have
coverage," you may have to pay a late enrollment pe
right to ask Medicare to review your late enrollment
"reconsideration." For example, you could request a
not count all of your creditable drug coverage or if y
explained whether your previous prescription drug
requesting a reconsideration are listed on the reque

Who Can Ask for a Reconsideration?
You or someone you name to act for you (your repre
If someone requests a reconsideration for you, he or
represent you with the request form. Proof could be
or an "Appointment of Representative" form. This la
http://www.medicare.gov/Basics/forms on the Wel
(see below) and ask for Form CMS-1696.

How Do I Ask for a Reconsideration?
The reconsideration request form is sent with this n
address or fax it to the number listed on the form wi
you got stating you had to pay a late enrollment pen
supports your case, like information about previous
If you wait more than 60 days, you must explain wh
decide if you had good cause to send a late request.

What Do I Need to Include with My LEP Reconsid
1. A completed, signed LEP reconsideration r
2. Copies of information you believe may hel
3. If you've named someone to act for you, a
represent you.

NOTE: Do not send original documents.

Where Can I Get More Information?
Call **Express Scripts Medicare™** (PDP) at **1.555.555.**
Service is available 24 hours a day, 7 days a week. TT
Or you can visit our website at **www.Express-Scripts.**

AP1414N2

Express Scripts
P.O. Box 14235
Lexington, KY 40512

EXPRESS SCRIPTS®
Medicare (PDP)

September 02, 2013

0000000-00-00054
123456789123/6032/0000//AFFID1234567//GROUP123456//LP214
JOHN Q. SAMPLE
100 GROUP123456 DRIVE
ANYCITY, ST 99999-5926

Sample Client Logo

Dear JOHN Q. SAMPLE:

We are writing today to update you with new information about your Medicare prescription drug plan. Starting 11/01/2012, you may be charged a late enrollment penalty (LEP) of $15.00 each month because our records show that you did not have creditable prescription drug coverage (as good as Medicare's) for 12 months after you were first eligible to sign up for Medicare prescription drug coverage. The period in which you did not have creditable coverage was 01/01/2012 to 12/31/2012.

While you are covered under **Express Scripts Medicare™** (PDP) for Client Name, your former employer or retiree group **may** pay the full amount of your LEP on your behalf. (You should contact your group benefits administrator if you are not sure whether you are responsible for paying the LEP.) If your former employer or retiree group pays the LEP amount for you but your coverage is terminated or you switch to another Medicare Part D plan, or your former employer or retiree group stops paying your LEP, you may be responsible for paying this amount (if you are still subject to an LEP).

If you received continuous coverage through your former employer or union group prior to being enrolled in Express Scripts Medicare, Client Name may also have the opportunity to attest on your behalf that you have had continuous coverage.

If you disagree with your late enrollment penalty, you can ask Medicare to reconsider (review) its decision. For example, you might disagree with the penalty for any of the following reasons:

- You got/get Extra Help from Medicare to pay for your prescription drug coverage.
- You were not informed that you did not have creditable prescription drug coverage (as good as Medicare's).

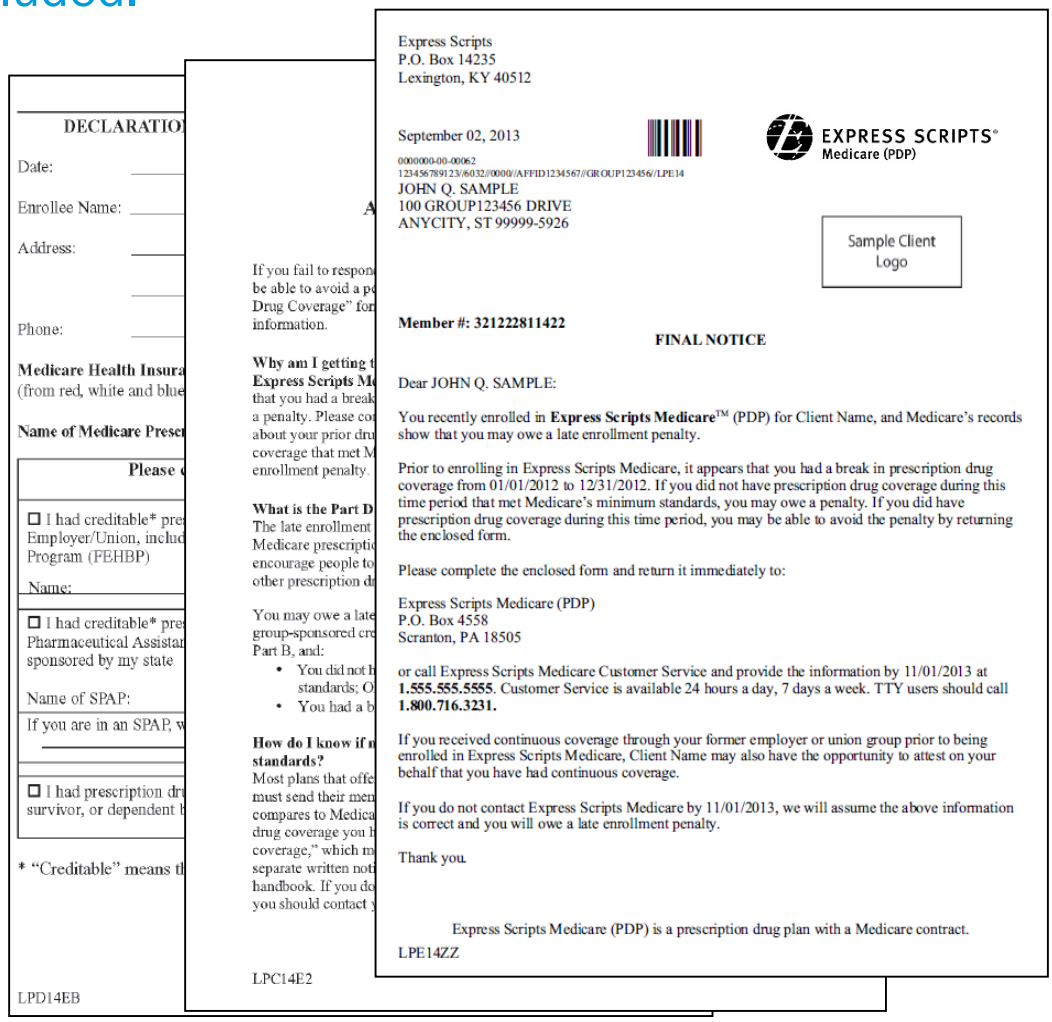
A notice explaining your right to a reconsideration of the LEP is included with this letter. **You must submit your reconsideration request within 60 days of the date of this letter, or Medicare may not consider your request.**

LP214ZZ

When	Within 10 days of CMS notification
Audience	Members identified by CMS who have a lapse in creditable coverage of 63 days or more and assessed an LEP
Client Logo	Yes

Implementation Communications: LEP Attestation Form Final Notice

This form is sent to CMS-identified lapse-in-coverage members requesting coverage details. An FAQ and a Declaration of Prior Prescription Drug Coverage is included.



Express Scripts
P.O. Box 14235
Lexington, KY 40512

September 02, 2013

0000000-00-00062
12345678912 3/6032//0000//AFFID1234567//GROUP123456//LPE14
JOHN Q. SAMPLE
100 GROUP123456 DRIVE
ANYCITY, ST 99999-5926

EXPRESS SCRIPTS® Medicare (PDP)

Sample Client Logo

Member #: 321222811422

FINAL NOTICE

Dear JOHN Q. SAMPLE:

You recently enrolled in **Express Scripts Medicare**™ (PDP) for Client Name, and Medicare's records show that you may owe a late enrollment penalty.

Prior to enrolling in Express Scripts Medicare, it appears that you had a break in prescription drug coverage from 01/01/2012 to 12/31/2012. If you did not have prescription drug coverage during this time period that met Medicare's minimum standards, you may owe a penalty. If you did have prescription drug coverage during this time period, you may be able to avoid the penalty by returning the enclosed form.

Please complete the enclosed form and return it immediately to:

Express Scripts Medicare (PDP)
P.O. Box 4558
Scranton, PA 18505

or call Express Scripts Medicare Customer Service and provide the information by 11/01/2013 at **1.555.555.5555**. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1.800.716.3231.**

If you received continuous coverage through your former employer or union group prior to being enrolled in Express Scripts Medicare, Client Name may also have the opportunity to attest on your behalf that you have had continuous coverage.

If you do not contact Express Scripts Medicare by 11/01/2013, we will assume the above information is correct and you will owe a late enrollment penalty.

Thank you.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.

LPE14ZZ

LPC14E2

LPD14EB

When	15 days after initial letter is sent if no response is received
Audience	Members identified by CMS who have a lapse in creditable coverage of 63 days or more
Client Logo	Yes

Ongoing Communications

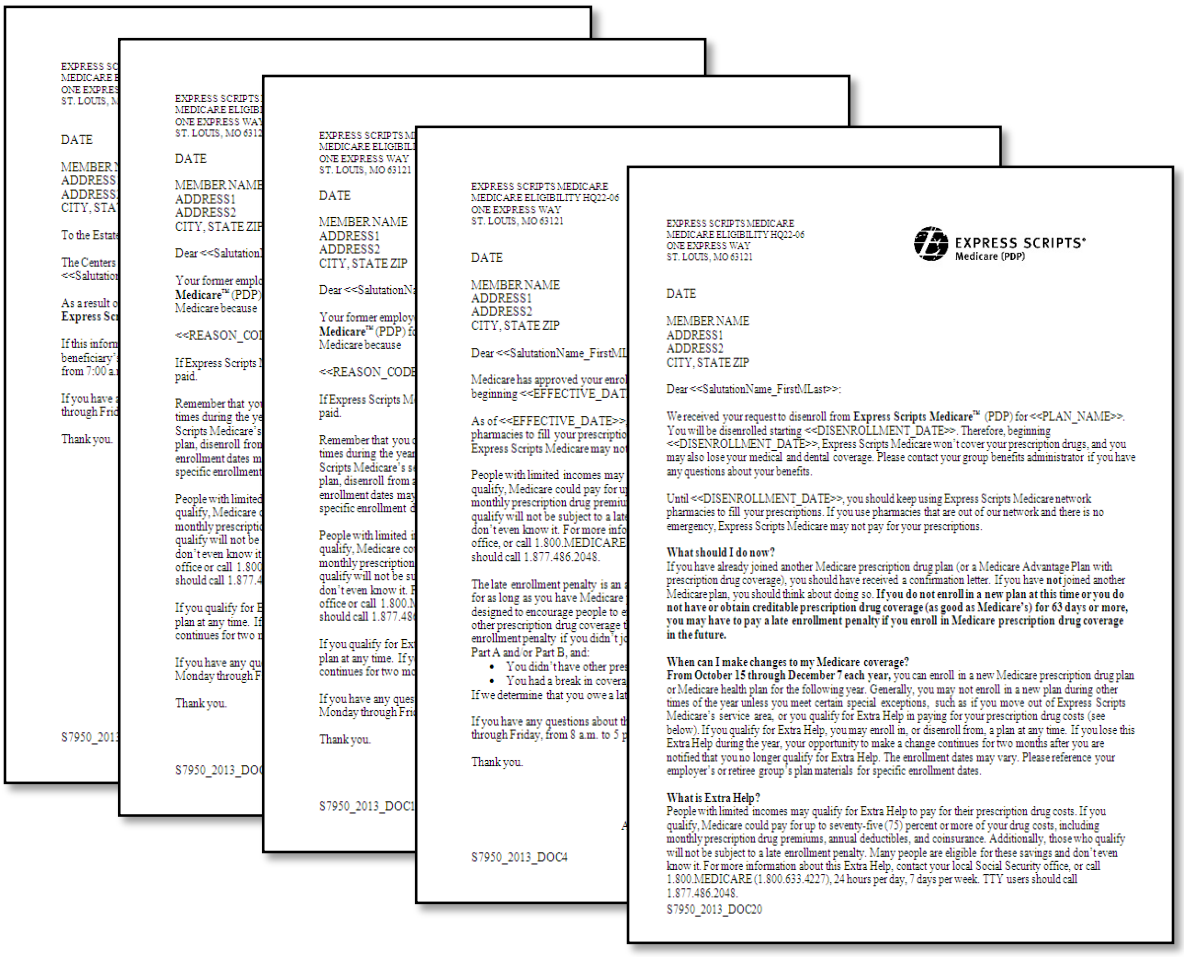
Ongoing Communications

Express Scripts is responsible for providing the CMS-required documents listed below:

Program	CMS Requirement / Overview
Late Enrollment Penalty (LEP)	• Sent out as any changes to a member's late enrollment penalty status or amount occur. Timing varies by letter from 10 days to 20 days from the time CMS provides Express Scripts with information regarding a particular member.
Enrollment / Disenrollment (Exhibit Letters)	• Provides members with details on enrollment and/or disenrollment status changes based upon CMS-provided member information.
Explanation of Benefits (EOB)	• Can be offered on demand to members who utilized the benefit the month prior. Provides all claim information, along with TrOOP costs and drug spend from the prior month.
Direct Claims	• Letters mailed in response to a member filing a direct claim for reimbursement for a drug they already received.
Coverage Determination	• Suite of letters to address the progress of a member's request for coverage of a medication. Includes confirmation of coverage of a drug, denial of coverage, and appeal rights and process.
Grievances	• Letters sent in response to a member filing a grievance (a complaint not related to prescription drug coverage).
Appeals	• Procedure for dealing with adverse coverage decisions.
Coordination of Benefits (COB)	• Letter is sent when existing 'other coverage' information appears on COB file received from CMS.
Member Recovery	• Mailing to support the notification of members with an open balance. Required to be sent within 45 days of identification of the balance.
Pharmacy Terminations	• Notification provided to inform members that a pharmacy they have been using is no longer part of the Express Scripts pharmacy network and provide members with alternatives.
Plan Administration	• Mailings related to plan administration, such as transition supply letters and formulary change letters.

Ongoing Communications: Exhibit Letters - Enrollment

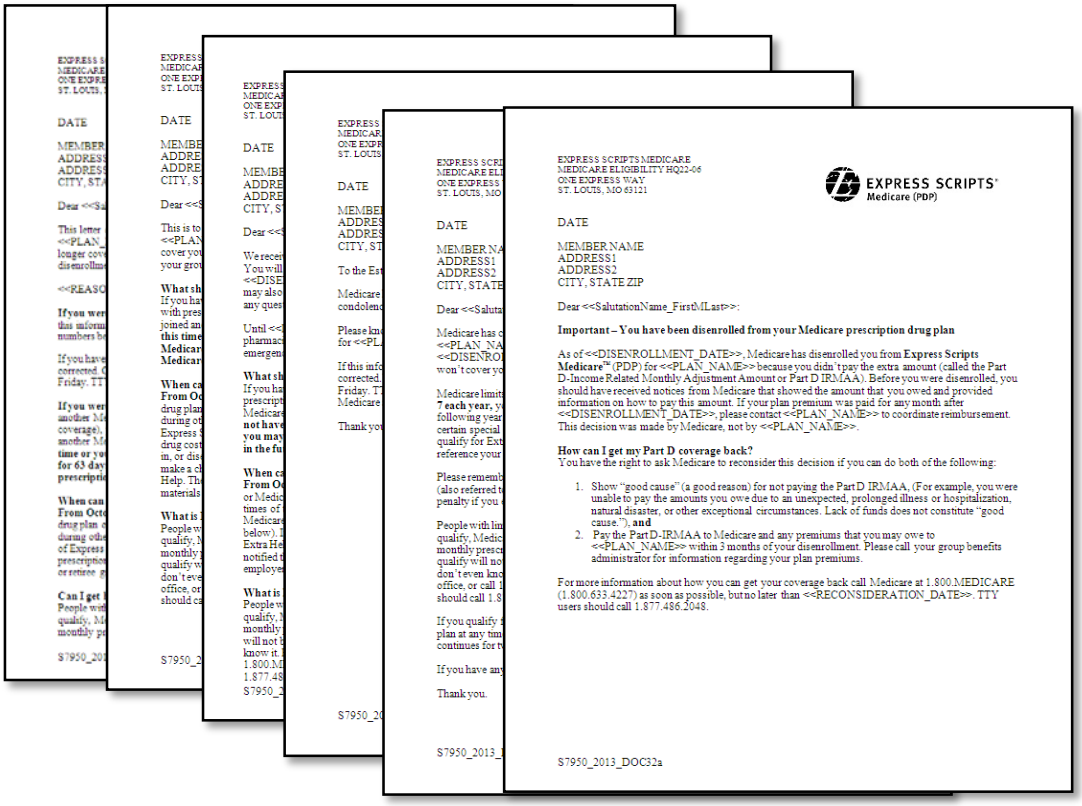
Provides details to members regarding their enrollment into the EGWP and includes: enrollment confirmation and acknowledgement, denial or rejection, member or CMS cancellation of enrollment, acknowledgement of member request to cancel enrollment, enrollment status updates to effective dates, and re-enrollments.



When	Within 10 calendar days of receipt of CMS enrollment response
Audience	Varies
Client Logo	Yes

Ongoing Communications: Exhibit Letters - Disenrollment

Provide details to members about their disenrollment from an EGWP and includes: acknowledgement of voluntary disenrollment request, confirmation of voluntary disenrollment, notice of involuntary disenrollment due to death, failure to pay plan premium or Part D-IRMAA, the member lives outside the plan's service area or is incarcerated, or the member no longer has either Medicare Part A or Part B.



EXPRESS SCRIPTS MEDICARE
MEDICARE ELIGIBILITY HQ22-06
ONE EXPRESS WAY
ST. LOUIS, MO 63121

EXPRESS SCRIPTS® Medicare (PDP)

DATE

MEMBER.NAME
ADDRESS1
ADDRESS2
CITY, STATE ZIP

Dear <<SalutationName_FirstMLast>>:

Important – You have been disenrolled from your Medicare prescription drug plan

As of <<DISENROLLMENT_DATE>>, Medicare has disenrolled you from **Express Scripts Medicare**™ (PDP) for <<PLAN_NAME>> because you didn't pay the extra amount (called the Part D-Income Related Monthly Adjustment Amount or Part D IRMAA). Before you were disenrolled, you should have received notices from Medicare that showed the amount that you owed and provided information on how to pay this amount. If your plan premium was paid for any month after <<DISENROLLMENT_DATE>>, please contact <<PLAN_NAME>> to coordinate reimbursement. This decision was made by Medicare, not by <<PLAN_NAME>>.

How can I get my Part D coverage back?
You have the right to ask Medicare to reconsider this decision if you can do both of the following:

1. Show "good cause" (a good reason) for not paying the Part D IRMAA. (For example, you were unable to pay the amounts you owe due to an unexpected, prolonged illness or hospitalization, natural disaster, or other exceptional circumstances. Lack of funds does not constitute "good cause."), **and**
2. Pay the Part D-IRMAA to Medicare and any premiums that you may owe to <<PLAN_NAME>> within 3 months of your disenrollment. Please call your group benefits administrator for information regarding your plan premiums.

For more information about how you can get your coverage back call Medicare at 1.800.MEDICARE (1.800.633.4227) as soon as possible, but no later than <<RECONSIDERATION_DATE>>. TTY users should call 1.877.486.2048.

S7950_2013_DOC32a

When	• Within 10 calendar days if disenrollment is due to a member's voluntary request, their death, failure to pay premiums, or failure to pay Part D-IRMAA • Within 21 days prior to the member's disenrollment date if disenrollment is involuntary because a member no longer has Medicare Part A and/or B, or the member moved outside the plan's service area
Audience	Varies
Client Logo	Yes

Ongoing Communications: Exhibit Letters – Additional Background

- CMS has developed a suite of letters that are required to be sent to Medicare Part D plan members based on various enrollment/disenrollment situations. While the entire suite of letters is required to be available to be sent to your membership, many of these letters will rarely be sent out due to the small occurrence of some of these situations. Based on data across our current client base, most Exhibit Letters will be sent to less than 1% of your member population.
- In the chart below, we have highlighted the most triggered and least triggered letters in order to give you a better sense of the types of Exhibit Letters that will go to your membership.

Sent most often – Top 3	Sent least often – Top 3
Disenrollment Due to Death	Reinstatement Notification Due to Correction of Erroneous Death
Confirmation of Disenrollment	Late Enrollment Penalty Information
Acknowledgment of Enrollment/ Temporary Member ID Card	Correction of Disenrollment Status

Ongoing Communications: Additional Information Request Form

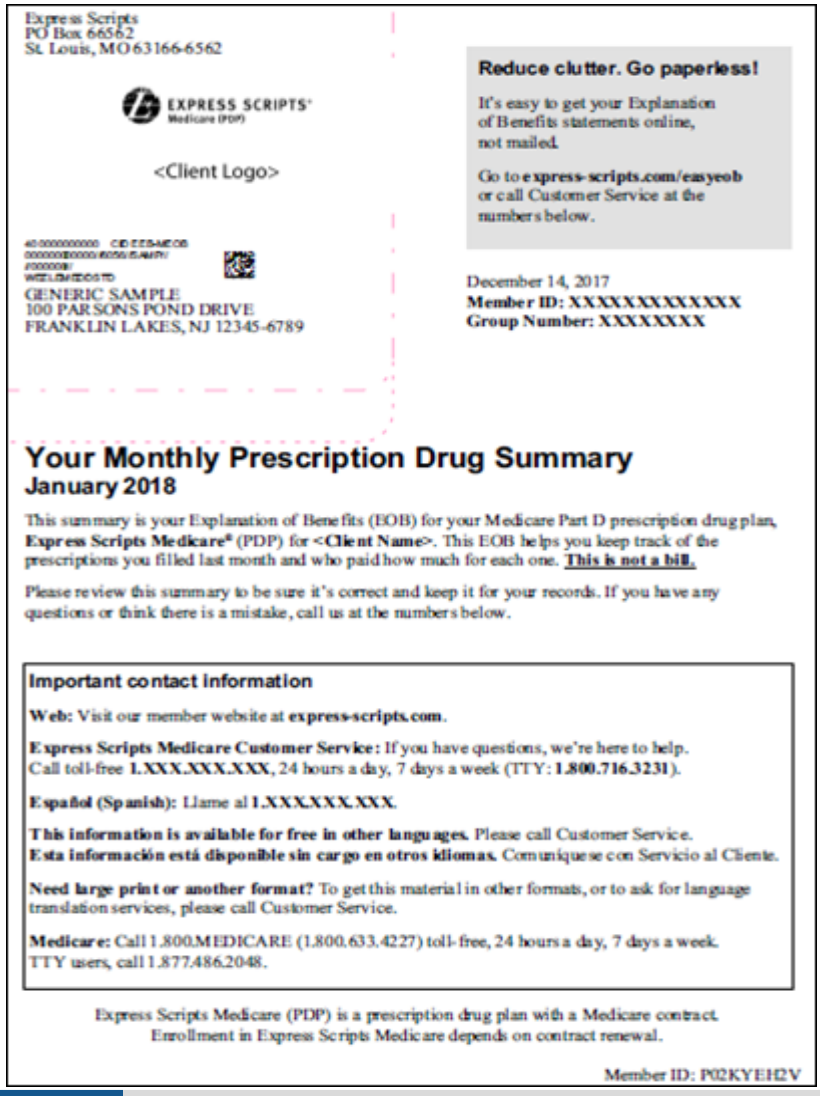
Sent to members when more information is needed to verify eligibility and additional enrollment information necessary to complete CMS enrollment.

- **This letter may be sent to a member when:**
- Street address or city update is needed
- State abbreviation or Zip code is invalid
- First name, last name, gender, or date of birth is a mismatch with Medicare
- Medicare Beneficiary Identifier (MBI) is invalid
- Further Information is required due to multiple errors existing for a member

When	As needed
Audience	Varies
Client Logo	Yes

Ongoing Communications: Explanation of Benefits (EOB)

Monthly statements to any members who have had claims processed in the previous month. These EOBs are specific to Medicare Part D and include all claim information, along with TrOOP costs and drug spend information.



Express Scripts
PO Box 66562
St. Louis, MO 63166-6562

EXPRESS SCRIPTS Medicare (PDP)

<Client Logo>

GENERIC SAMPLE
100 PARSONS POND DRIVE
FRANKLIN LAKES, NJ 12345-6789

Reduce clutter. Go paperless!

It's easy to get your Explanation of Benefits statements online, not mailed.

Go to **express-scripts.com/easyeob** or call Customer Service at the numbers below.

December 14, 2017
Member ID: XXXXXXXXXXXX
Group Number: XXXXXXXX

Your Monthly Prescription Drug Summary
January 2018

This summary is your Explanation of Benefits (EOB) for your Medicare Part D prescription drug plan, **Express Scripts Medicare®** (PDP) for **<Client Name>**. This EOB helps you keep track of the prescriptions you filled last month and who paid how much for each one. **This is not a bill.**

Please review this summary to be sure it's correct and keep it for your records. If you have any questions or think there is a mistake, call us at the numbers below.

Important contact information

Web: Visit our member website at **express-scripts.com**.

Express Scripts Medicare Customer Service: If you have questions, we're here to help. Call toll-free **1.XXX.XXX.XXX**, 24 hours a day, 7 days a week (TTY: **1.800.716.3231**).

Español (Spanish): Llame al **1.XXX.XXX.XXX**.

This information is available for free in other languages. Please call Customer Service.
Esta información está disponible sin cargo en otros idiomas. Comuníquese con Servicio al Cliente.

Need large print or another format? To get this material in other formats, or to ask for language translation services, please call Customer Service.

Medicare: Call 1.800.MEDICARE (1.800.633.4227) toll-free, 24 hours a day, 7 days a week. TTY users, call 1.877.486.2048.

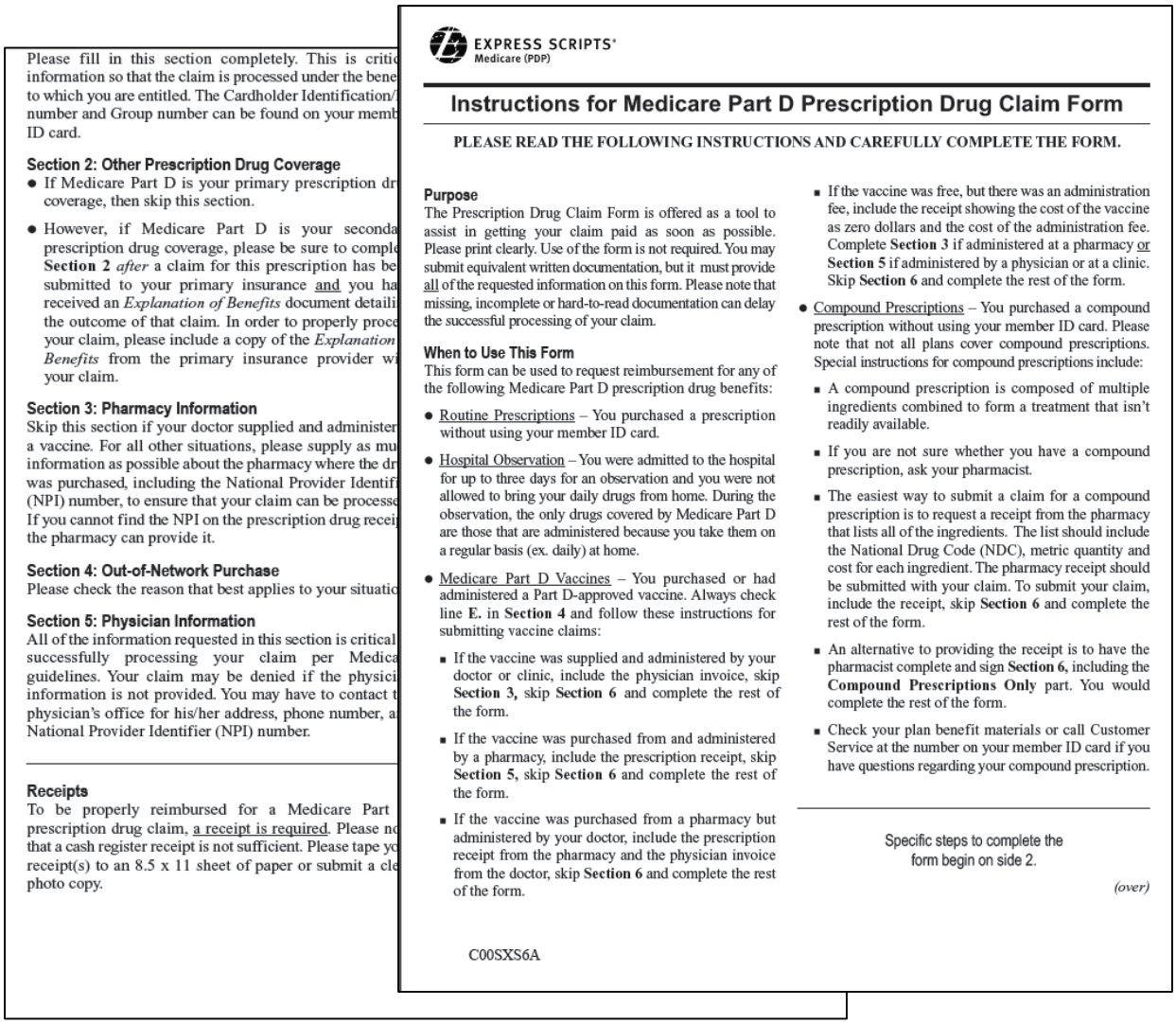
Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. Enrollment in Express Scripts Medicare depends on contract renewal.

Member ID: P02KYEH2V

When	Monthly or on demand
Audience	Members with activity during the prior month
Client Logo	Yes

Ongoing Communications: Direct Claims Form

This form allows members to submit a claim for reimbursement for a Part D-covered medication dispensed by a nonparticipating pharmacy.



Please fill in this section completely. This is critic
information so that the claim is processed under the bene
to which you are entitled. The Cardholder Identification/
number and Group number can be found on your memb
ID card.

Section 2: Other Prescription Drug Coverage

- If Medicare Part D is your primary prescription dr
coverage, then skip this section.
- However, if Medicare Part D is your seconda
prescription drug coverage, please be sure to compl
Section 2 *after* a claim for this prescription has be
submitted to your primary insurance and you ha
received an *Explanation of Benefits* document detaili
the outcome of that claim. In order to properly proce
your claim, please include a copy of the *Explanation*
Benefits from the primary insurance provider wi
your claim.

Section 3: Pharmacy Information

Skip this section if your doctor supplied and administer
a vaccine. For all other situations, please supply as mu
information as possible about the pharmacy where the dr
was purchased, including the National Provider Identifi
(NPI) number, to ensure that your claim can be processe
If you cannot find the NPI on the prescription drug recei
the pharmacy can provide it.

Section 4: Out-of-Network Purchase

Please check the reason that best applies to your situatio

Section 5: Physician Information

All of the information requested in this section is critical
successfully processing your claim per Medica
guidelines. Your claim may be denied if the physici
information is not provided. You may have to contact t
physician's office for his/her address, phone number, a
National Provider Identifier (NPI) number.

Receipts

To be properly reimbursed for a Medicare Part
prescription drug claim, a receipt is required. Please n
that a cash register receipt is not sufficient. Please tape yo
receipt(s) to an 8.5 x 11 sheet of paper or submit a cle
photo copy.

EXPRESS SCRIPTS®
Medicare (PDP)

Instructions for Medicare Part D Prescription Drug Claim Form

PLEASE READ THE FOLLOWING INSTRUCTIONS AND CAREFULLY COMPLETE THE FORM.

Purpose

The Prescription Drug Claim Form is offered as a tool to assist in getting your claim paid as soon as possible. Please print clearly. Use of the form is not required. You may submit equivalent written documentation, but it must provide all of the requested information on this form. Please note that missing, incomplete or hard-to-read documentation can delay the successful processing of your claim.

When to Use This Form

This form can be used to request reimbursement for any of the following Medicare Part D prescription drug benefits:

- Routine Prescriptions – You purchased a prescription without using your member ID card.
- Hospital Observation – You were admitted to the hospital for up to three days for an observation and you were not allowed to bring your daily drugs from home. During the observation, the only drugs covered by Medicare Part D are those that are administered because you take them on a regular basis (ex. daily) at home.
- Medicare Part D Vaccines – You purchased or had administered a Part D-approved vaccine. Always check line **E.** in **Section 4** and follow these instructions for submitting vaccine claims:
  - If the vaccine was supplied and administered by your doctor or clinic, include the physician invoice, skip **Section 3,** skip **Section 6** and complete the rest of the form.
  - If the vaccine was purchased from and administered by a pharmacy, include the prescription receipt, skip **Section 5,** skip **Section 6** and complete the rest of the form.
  - If the vaccine was purchased from a pharmacy but administered by your doctor, include the prescription receipt from the pharmacy and the physician invoice from the doctor, skip **Section 6** and complete the rest of the form.
  - If the vaccine was free, but there was an administration fee, include the receipt showing the cost of the vaccine as zero dollars and the cost of the administration fee. Complete **Section 3** if administered at a pharmacy or **Section 5** if administered by a physician or at a clinic. Skip **Section 6** and complete the rest of the form.
- Compound Prescriptions – You purchased a compound prescription without using your member ID card. Please note that not all plans cover compound prescriptions. Special instructions for compound prescriptions include:
  - A compound prescription is composed of multiple ingredients combined to form a treatment that isn't readily available.
  - If you are not sure whether you have a compound prescription, ask your pharmacist.
  - The easiest way to submit a claim for a compound prescription is to request a receipt from the pharmacy that lists all of the ingredients. The list should include the National Drug Code (NDC), metric quantity and cost for each ingredient. The pharmacy receipt should be submitted with your claim. To submit your claim, include the receipt, skip **Section 6** and complete the rest of the form.
  - An alternative to providing the receipt is to have the pharmacist complete and sign **Section 6,** including the **Compound Prescriptions Only** part. You would complete the rest of the form.
  - Check your plan benefit materials or call Customer Service at the number on your member ID card if you have questions regarding your compound prescription.

Specific steps to complete the form begin on side 2.

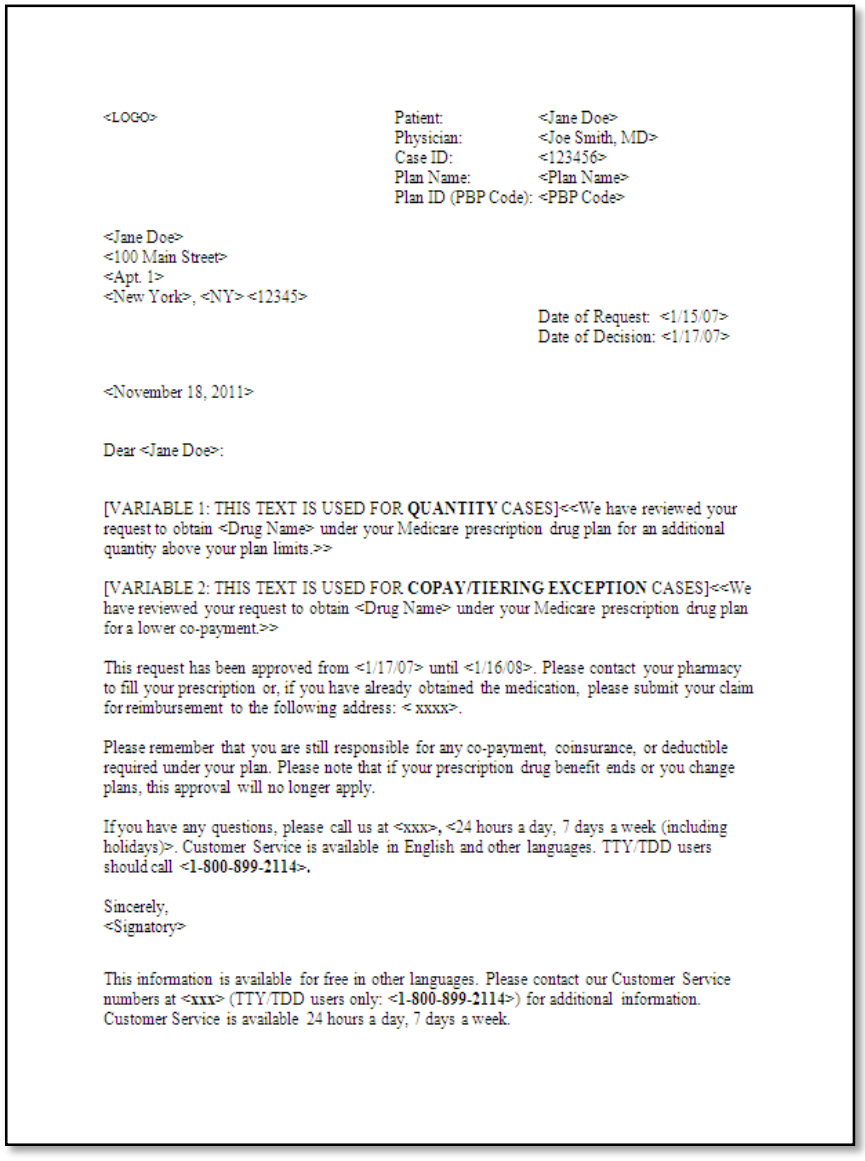
(over)

C00SXS6A

When	Upon request – available on the website
Audience	Medicare members

Ongoing Communications: Coverage Determination Approval

This is a notice of approval of a coverage determination request.



<LOGO>

Patient: <Jane Doe>
Physician: <Joe Smith, MD>
Case ID: <123456>
Plan Name: <Plan Name>
Plan ID (PBP Code): <PBP Code>

<Jane Doe>
<100 Main Street>
<Apt. 1>
<New York>, <NY> <12345>

Date of Request: <1/15/07>
Date of Decision: <1/17/07>

<November 18, 2011>

Dear <Jane Doe>:

[VARIABLE 1: THIS TEXT IS USED FOR **QUANTITY** CASES]<<We have reviewed your request to obtain <Drug Name> under your Medicare prescription drug plan for an additional quantity above your plan limits.>>

[VARIABLE 2: THIS TEXT IS USED FOR **COPAY/TIERING EXCEPTION** CASES]<<We have reviewed your request to obtain <Drug Name> under your Medicare prescription drug plan for a lower co-payment.>>

This request has been approved from <1/17/07> until <1/16/08>. Please contact your pharmacy to fill your prescription or, if you have already obtained the medication, please submit your claim for reimbursement to the following address: < xxxx>.

Please remember that you are still responsible for any co-payment, coinsurance, or deductible required under your plan. Please note that if your prescription drug benefit ends or you change plans, this approval will no longer apply.

If you have any questions, please call us at <xxx>, <24 hours a day, 7 days a week (including holidays)>. Customer Service is available in English and other languages. TTY/TDD users should call **<1-800-899-2114>.**

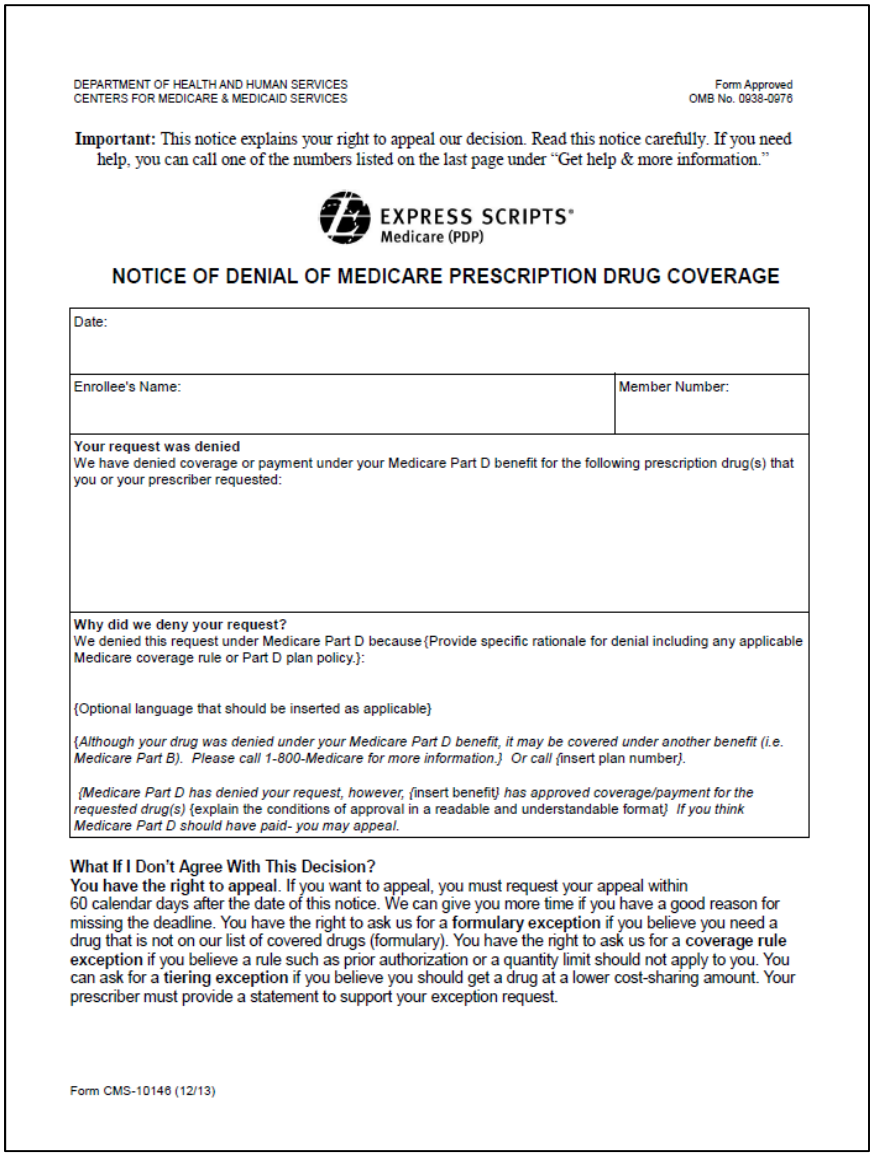
Sincerely,
<Signatory>

This information is available for free in other languages. Please contact our Customer Service numbers at <**xxx**> (TTY/TDD users only: <**1-800-899-2114**>) for additional information. Customer Service is available 24 hours a day, 7 days a week.

When	As needed
Audience	Members who receive an approval of their coverage request

Ongoing Communications: Coverage Determination Denial

Notice of denial of coverage determination request. A redetermination request is included in this mailing.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0976

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

EXPRESS SCRIPTS®
Medicare (PDP)

NOTICE OF DENIAL OF MEDICARE PRESCRIPTION DRUG COVERAGE

Date:	
Enrollee's Name:	Member Number:

Your request was denied
We have denied coverage or payment under your Medicare Part D benefit for the following prescription drug(s) that you or your prescriber requested:

Why did we deny your request?
We denied this request under Medicare Part D because {Provide specific rationale for denial including any applicable Medicare coverage rule or Part D plan policy.}:

{Optional language that should be inserted as applicable}

*{Although your drug was denied under your Medicare Part D benefit, it may be covered under another benefit (i.e. Medicare Part B). Please call 1-800-Medicare for more information.} Or call {*insert plan number*}.*

*{Medicare Part D has denied your request, however, {*insert benefit*} has approved coverage/payment for the requested drug(s)* {explain the conditions of approval in a readable and understandable format*} If you think Medicare Part D should have paid- you may appeal.*

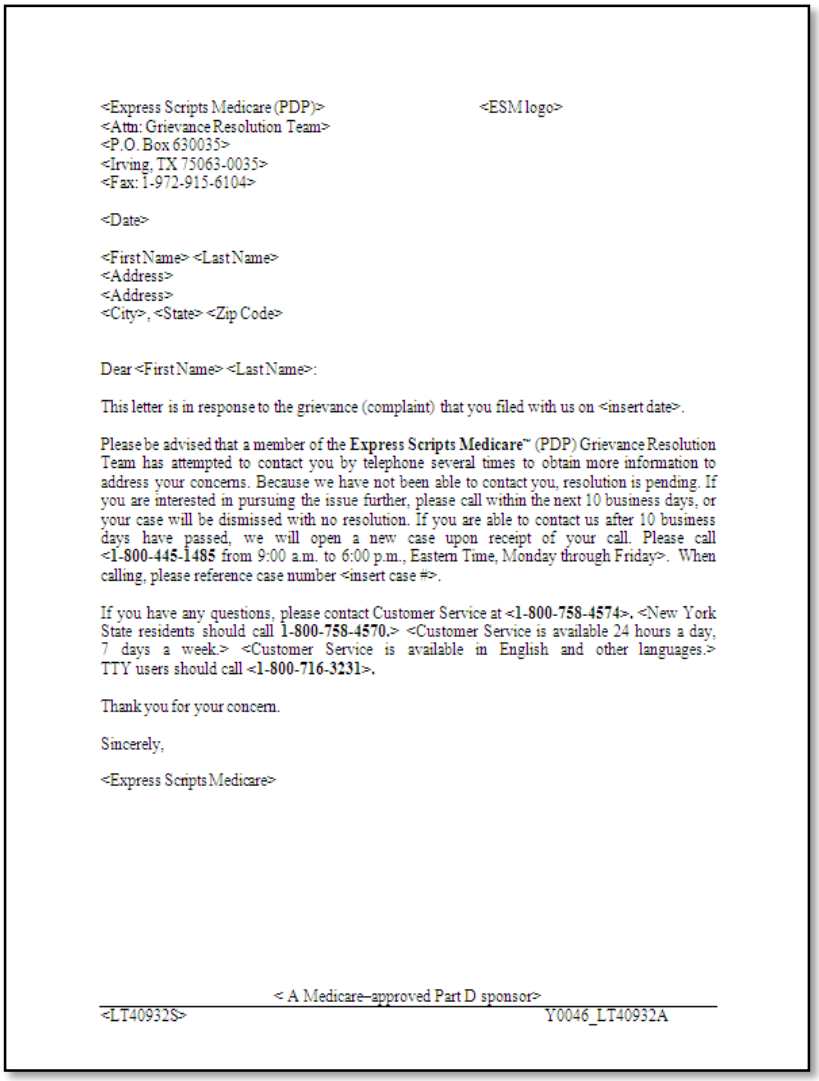
What If I Don't Agree With This Decision?
You have the right to appeal. If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. You have the right to ask us for a **formulary exception** if you believe you need a drug that is not on our list of covered drugs (formulary). You have the right to ask us for a **coverage rule exception** if you believe a rule such as prior authorization or a quantity limit should not apply to you. You can ask for a **tiering exception** if you believe you should get a drug at a lower cost-sharing amount. Your prescriber must provide a statement to support your exception request.

Form CMS-10146 (12/13)

When	As needed
Audience	Members who receive a denial of their coverage request

Ongoing Communications: Grievance Letter

This letter is sent when our Grievance Resolution Team has attempted to contact the member to request more information about the grievance that was filed, but has been unsuccessful.



<Express Scripts Medicare (PDP)> <ESM logo>
<Attn: Grievance Resolution Team>
<P.O. Box 630035>
<Irving, TX 75063-0035>
<Fax: 1-972-915-6104>

<Date>

<First Name> <Last Name>
<Address>
<Address>
<City>, <State> <Zip Code>

Dear <First Name> <Last Name>:

This letter is in response to the grievance (complaint) that you filed with us on <insert date>.

Please be advised that a member of the **Express Scripts Medicare™** (PDP) Grievance Resolution Team has attempted to contact you by telephone several times to obtain more information to address your concerns. Because we have not been able to contact you, resolution is pending. If you are interested in pursuing the issue further, please call within the next 10 business days, or your case will be dismissed with no resolution. If you are able to contact us after 10 business days have passed, we will open a new case upon receipt of your call. Please call **<1-800-445-1485** from 9:00 a.m. to 6:00 p.m., Eastern Time, Monday through Friday>. When calling, please reference case number <insert case #>.

If you have any questions, please contact Customer Service at **<1-800-758-4574>.** <New York State residents should call **1-800-758-4570.**> <Customer Service is available 24 hours a day, 7 days a week.> <Customer Service is available in English and other languages.> TTY users should call **<1-800-716-3231>.**

Thank you for your concern.

Sincerely,

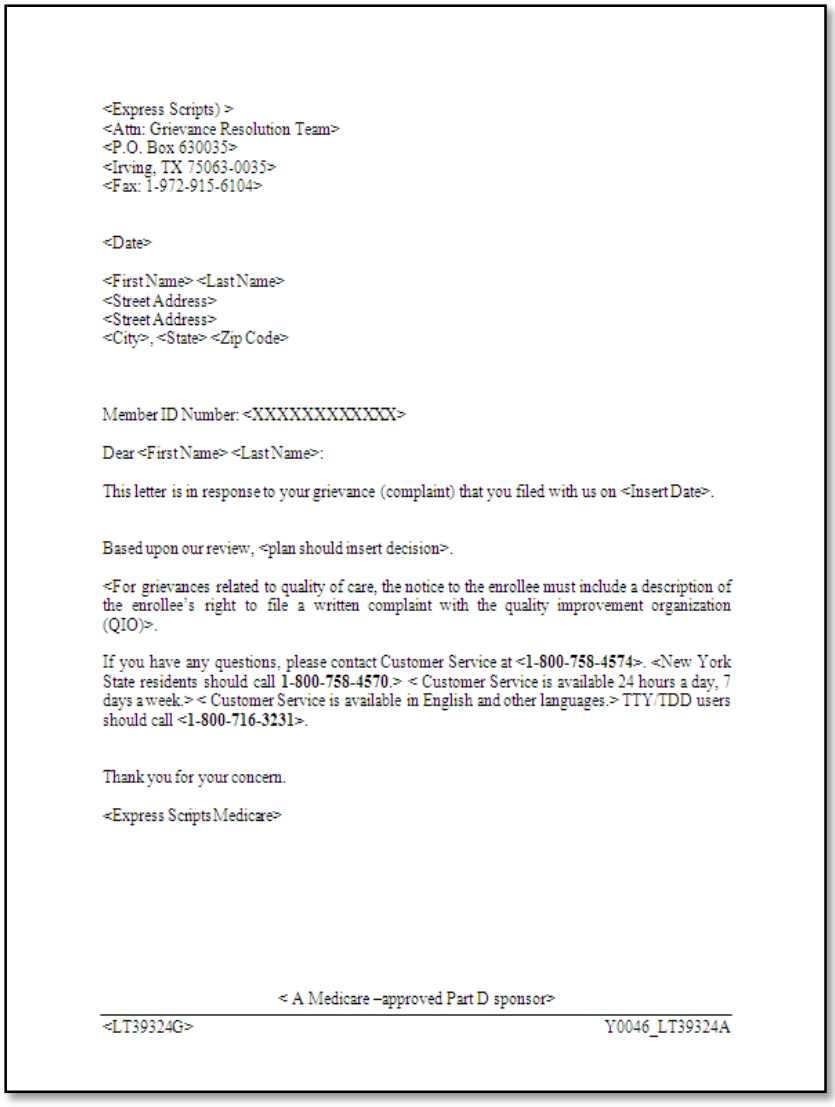
<Express Scripts Medicare>

< A Medicare–approved Part D sponsor>
<LT40932S> Y0046_LT40932A

When	As needed
Audience	Members who filed a grievance

Ongoing Communications: Grievance Decision Letter

This letter informs a member of the plan's grievance decision.



<Express Scripts) >
<Attn: Grievance Resolution Team>
<P.O. Box 630035>
<Irving, TX 75063-0035>
<Fax: 1-972-915-6104>

<Date>

<First Name> <Last Name>
<Street Address>
<Street Address>
<City>, <State> <Zip Code>

Member ID Number: <XXXXXXXXXXXX>

Dear <First Name> <Last Name>:

This letter is in response to your grievance (complaint) that you filed with us on <Insert Date>.

Based upon our review, <plan should insert decision>.

<For grievances related to quality of care, the notice to the enrollee must include a description of the enrollee's right to file a written complaint with the quality improvement organization (QIO)>.

If you have any questions, please contact Customer Service at <**1-800-758-4574**>. <New York State residents should call **1-800-758-4570**.> < Customer Service is available 24 hours a day, 7 days a week.> < Customer Service is available in English and other languages.> TTY/TDD users should call <**1-800-716-3231**>.

Thank you for your concern.

<Express Scripts Medicare>

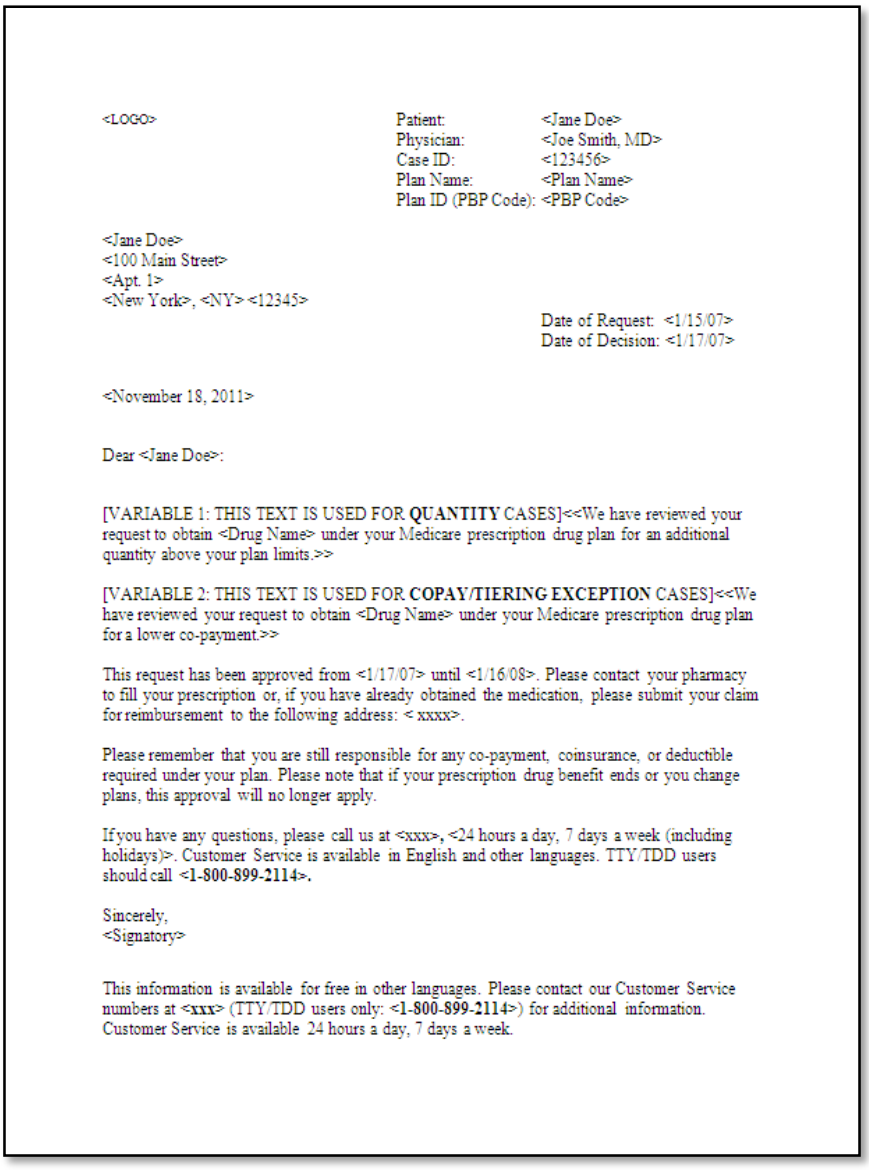
< A Medicare –approved Part D sponsor>

<LT39324G> Y0046_LT39324A

When	As needed
Audience	Members who filed a grievance

Ongoing Communications: Appeals Approval

This is a notice of approval for an appeals request.



<LOGO>

Patient: <Jane Doe>
Physician: <Joe Smith, MD>
Case ID: <123456>
Plan Name: <Plan Name>
Plan ID (PBP Code): <PBP Code>

<Jane Doe>
<100 Main Street>
<Apt. 1>
<New York>, <NY> <12345>

Date of Request: <1/15/07>
Date of Decision: <1/17/07>

<November 18, 2011>

Dear <Jane Doe>:

[VARIABLE 1: THIS TEXT IS USED FOR **QUANTITY** CASES]<<We have reviewed your request to obtain <Drug Name> under your Medicare prescription drug plan for an additional quantity above your plan limits.>>

[VARIABLE 2: THIS TEXT IS USED FOR **COPAY/TIERING EXCEPTION** CASES]<<We have reviewed your request to obtain <Drug Name> under your Medicare prescription drug plan for a lower co-payment.>>

This request has been approved from <1/17/07> until <1/16/08>. Please contact your pharmacy to fill your prescription or, if you have already obtained the medication, please submit your claim for reimbursement to the following address: < xxxx>.

Please remember that you are still responsible for any co-payment, coinsurance, or deductible required under your plan. Please note that if your prescription drug benefit ends or you change plans, this approval will no longer apply.

If you have any questions, please call us at <xxx>, <24 hours a day, 7 days a week (including holidays)>. Customer Service is available in English and other languages. TTY/TDD users should call **<1-800-899-2114>.**

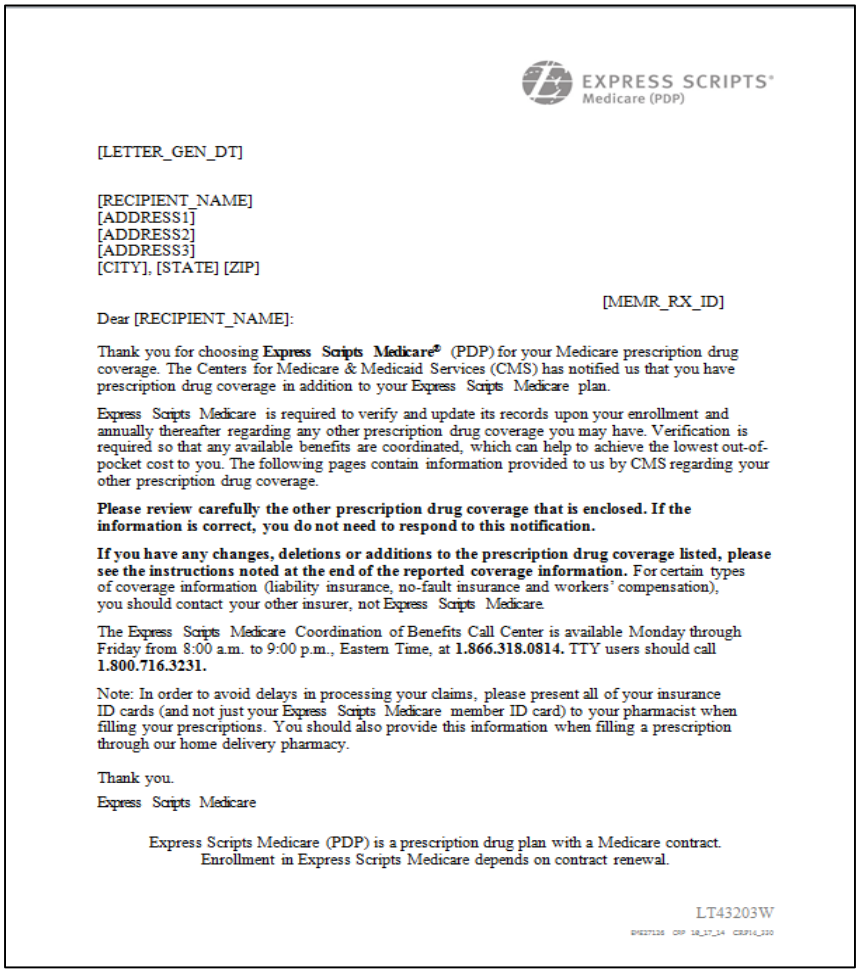
Sincerely,
<Signatory>

This information is available for free in other languages. Please contact our Customer Service numbers at <xxx> (TTY/TDD users only: **<1-800-899-2114>**) for additional information. Customer Service is available 24 hours a day, 7 days a week.

When	As needed
Audience	Members that receive an approval of their appeals request

Ongoing Communications: Coordination of Benefits (COB)

This letter is sent when existing "other coverage" information appears on the COB file received from CMS. Members are asked to review the information and report any updates (corrections to existing information and new coverage information) to Express Scripts.



EXPRESS SCRIPTS®
Medicare (PDP)

[LETTER_GEN_DT]

[RECIPIENT_NAME]
[ADDRESS1]
[ADDRESS2]
[ADDRESS3]
[CITY], [STATE] [ZIP]

[MEMR_RX_ID]

Dear [RECIPIENT_NAME]:

Thank you for choosing **Express Scripts Medicare®** (PDP) for your Medicare prescription drug coverage. The Centers for Medicare & Medicaid Services (CMS) has notified us that you have prescription drug coverage in addition to your Express Scripts Medicare plan.

Express Scripts Medicare is required to verify and update its records upon your enrollment and annually thereafter regarding any other prescription drug coverage you may have. Verification is required so that any available benefits are coordinated, which can help to achieve the lowest out-of-pocket cost to you. The following pages contain information provided to us by CMS regarding your other prescription drug coverage.

Please review carefully the other prescription drug coverage that is enclosed. If the information is correct, you do not need to respond to this notification.

If you have any changes, deletions or additions to the prescription drug coverage listed, please see the instructions noted at the end of the reported coverage information. For certain types of coverage information (liability insurance, no-fault insurance and workers' compensation), you should contact your other insurer, not Express Scripts Medicare.

The Express Scripts Medicare Coordination of Benefits Call Center is available Monday through Friday from 8:00 a.m. to 9:00 p.m., Eastern Time, at **1.866.318.0814.** TTY users should call **1.800.716.3231.**

Note: In order to avoid delays in processing your claims, please present all of your insurance ID cards (and not just your Express Scripts Medicare member ID card) to your pharmacist when filling your prescriptions. You should also provide this information when filling a prescription through our home delivery pharmacy.

Thank you.

Express Scripts Medicare

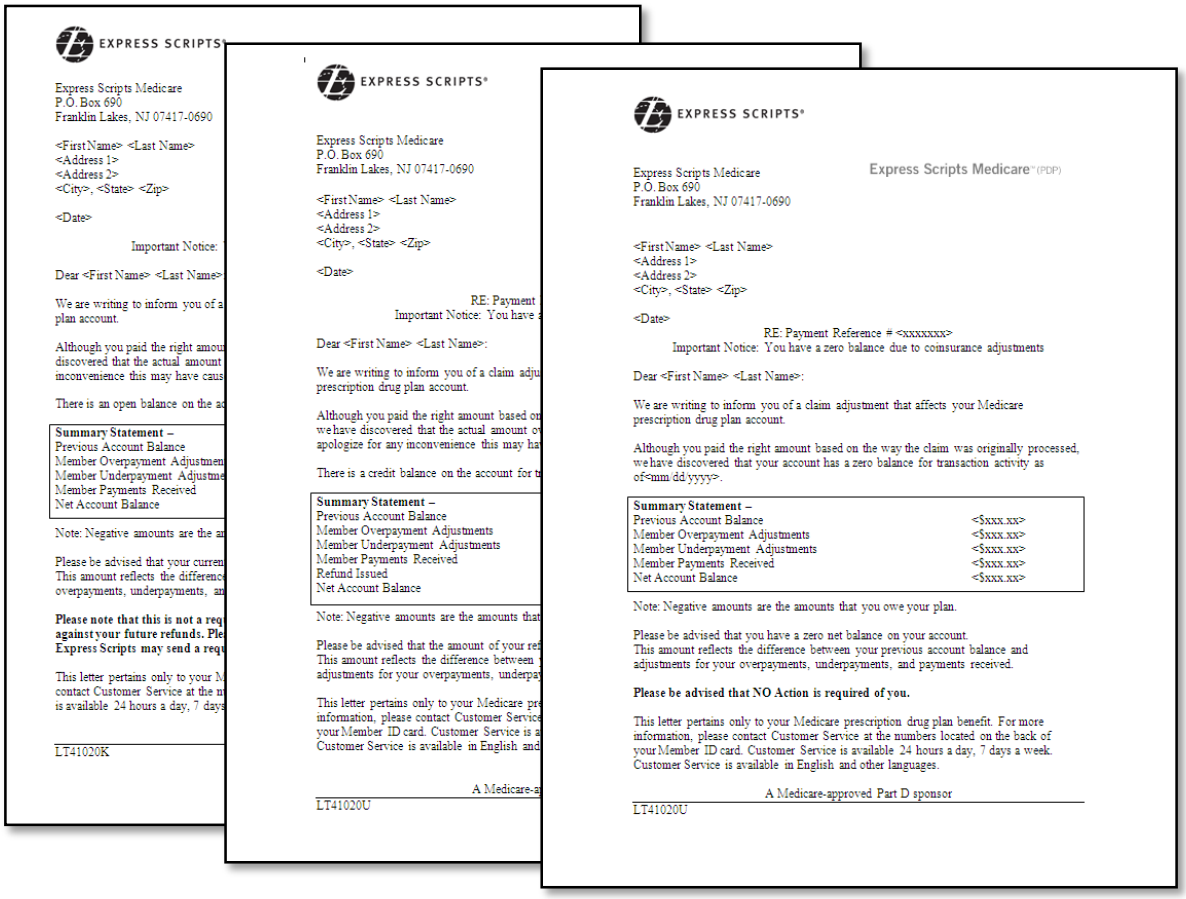
Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

LT43203W

When	Within 30 days of enrollment for new enrollees and annually for current enrollees
Audience	Members with existing "other coverage" COB information on file with CMS

Ongoing Communications: Member Recovery Letter

This notice is sent to members who have had a retroactive change in their level of eligibility for Extra Help, resulting in one of three scenarios: 1) an underpayment of their prescription drug copayments/coinsurance 2) an overpayment or 3) an adjustment resulting in a zero balance on their account.



Express Scripts Medicare
P.O. Box 690
Franklin Lakes, NJ 07417-0690

<First Name> <Last Name>
<Address 1>
<Address 2>
<City>, <State> <Zip>

<Date>

Important Notice:

Dear <First Name> <Last Name>

We are writing to inform you of a
plan account.

Although you paid the right amou
discovered that the actual amount
inconvenience this may have caus

There is an open balance on the ac

Summary Statement –
Previous Account Balance
Member Overpayment Adjustmen
Member Underpayment Adjustme
Member Payments Received
Net Account Balance

Note: Negative amounts are the a

Please be advised that your curren
This amount reflects the differenc
overpayments, underpayments, a

Please note that this is not a req
against your future refunds. Ple
Express Scripts may send a requ

This letter pertains only to your M
contact Customer Service at the n
is available 24 hours a day, 7 days

LT41020K

EXPRESS SCRIPTS®

Express Scripts Medicare
P.O. Box 690
Franklin Lakes, NJ 07417-0690

<First Name> <Last Name>
<Address 1>
<Address 2>
<City>, <State> <Zip>

<Date>

RE: Payment
Important Notice: You have

Dear <First Name> <Last Name>:

We are writing to inform you of a claim adju
prescription drug plan account.

Although you paid the right amount based on
we have discovered that the actual amount o
apologize for any inconvenience this may ha

There is a credit balance on the account for t

Summary Statement –
Previous Account Balance
Member Overpayment Adjustments
Member Underpayment Adjustments
Member Payments Received
Refund Issued
Net Account Balance

Note: Negative amounts are the amounts that

Please be advised that the amount of your ref
This amount reflects the difference between
adjustments for your overpayments, underpay

This letter pertains only to your Medicare pr
information, please contact Customer Service
your Member ID card. Customer Service is a
Customer Service is available in English and

A Medicare-a

LT41020U

EXPRESS SCRIPTS®

Express Scripts Medicare™ (PDP)

Express Scripts Medicare
P.O. Box 690
Franklin Lakes, NJ 07417-0690

<First Name> <Last Name>
<Address 1>
<Address 2>
<City>, <State> <Zip>

<Date>

RE: Payment Reference # <xxxxxxx>
Important Notice: You have a zero balance due to coinsurance adjustments

Dear <First Name> <Last Name>:

We are writing to inform you of a claim adjustment that affects your Medicare prescription drug plan account.

Although you paid the right amount based on the way the claim was originally processed, we have discovered that your account has a zero balance for transaction activity as of<mm/dd/yyyy>.

Summary Statement –	
Previous Account Balance	<$xxx.xx>
Member Overpayment Adjustments	<$xxx.xx>
Member Underpayment Adjustments	<$xxx.xx>
Member Payments Received	<$xxx.xx>
Net Account Balance	<$xxx.xx>

Note: Negative amounts are the amounts that you owe your plan.

Please be advised that you have a zero net balance on your account.
This amount reflects the difference between your previous account balance and adjustments for your overpayments, underpayments, and payments received.

Please be advised that NO Action is required of you.

This letter pertains only to your Medicare prescription drug plan benefit. For more information, please contact Customer Service at the numbers located on the back of your Member ID card. Customer Service is available 24 hours a day, 7 days a week. Customer Service is available in English and other languages.

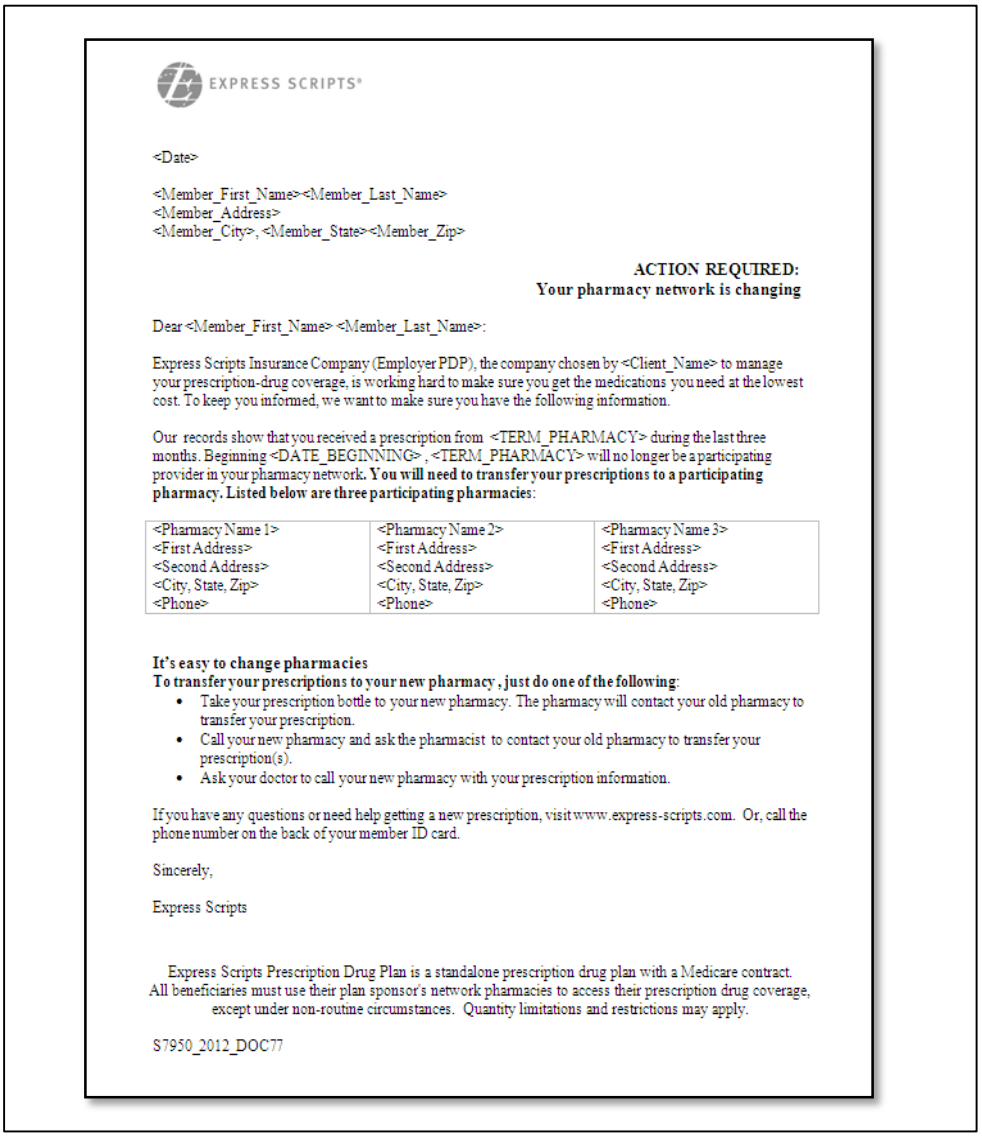
A Medicare-approved Part D sponsor

LT41020U

When	Within 45 days of plan's receipt of complete information regarding claims adjustment
Audience	Members experiencing a retroactive change in their level of Extra Help, or a change in their low-income subsidy status resulting in an over or underpayment on their account

Ongoing Communications: Pharmacy Termination

Informs members that a pharmacy they have used is no longer part of the Express Scripts pharmacy network.



EXPRESS SCRIPTS®

<Date>

<Member_First_Name><Member_Last_Name>
<Member_Address>
<Member_City>, <Member_State><Member_Zip>

ACTION REQUIRED:
Your pharmacy network is changing

Dear <Member_First_Name> <Member_Last_Name>:

Express Scripts Insurance Company (Employer PDP), the company chosen by <Client_Name> to manage your prescription-drug coverage, is working hard to make sure you get the medications you need at the lowest cost. To keep you informed, we want to make sure you have the following information.

Our records show that you received a prescription from <TERM_PHARMACY> during the last three months. Beginning <DATE_BEGINNING> , <TERM_PHARMACY> will no longer be a participating provider in your pharmacy network. **You will need to transfer your prescriptions to a participating pharmacy. Listed below are three participating pharmacies**:

<Pharmacy Name 1> <First Address> <Second Address> <City, State, Zip> <Phone>	<Pharmacy Name 2> <First Address> <Second Address> <City, State, Zip> <Phone>	<Pharmacy Name 3> <First Address> <Second Address> <City, State, Zip> <Phone>

It's easy to change pharmacies
To transfer your prescriptions to your new pharmacy , just do one of the following:

- Take your prescription bottle to your new pharmacy. The pharmacy will contact your old pharmacy to transfer your prescription.
- Call your new pharmacy and ask the pharmacist to contact your old pharmacy to transfer your prescription(s).
- Ask your doctor to call your new pharmacy with your prescription information.

If you have any questions or need help getting a new prescription, visit www.express-scripts.com. Or, call the phone number on the back of your member ID card.

Sincerely,

Express Scripts

Express Scripts Prescription Drug Plan is a standalone prescription drug plan with a Medicare contract. All beneficiaries must use their plan sponsor's network pharmacies to access their prescription drug coverage, except under non-routine circumstances. Quantity limitations and restrictions may apply.

S7950_2012_DOC77

When	As needed
Audience	Members who have medication dispensed by a pharmacy terming from the Express Scripts network

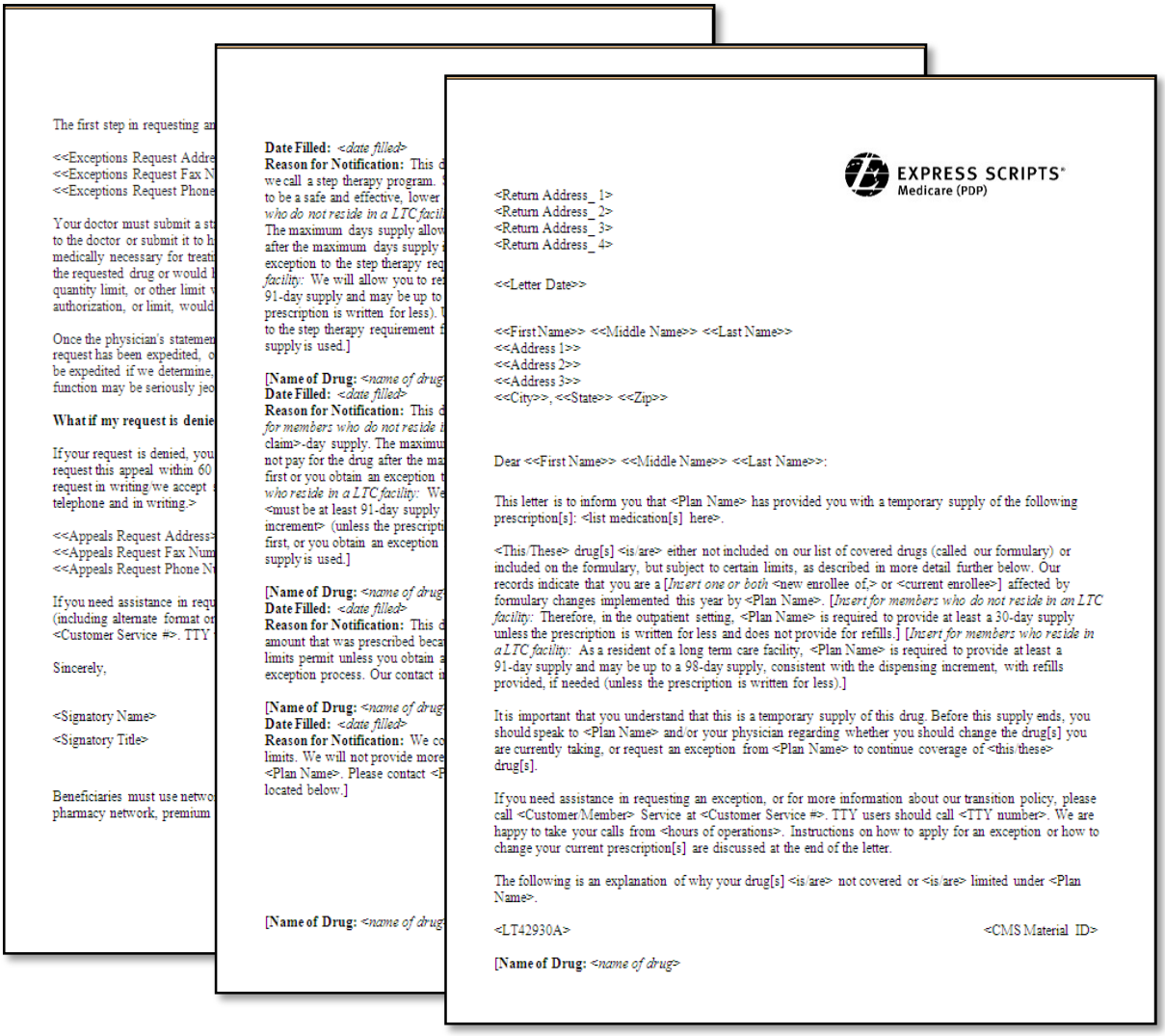
Ongoing Communications: Plan Administration Communications

Express Scripts is responsible for the Plan Administration mailings listed below:

Program	CMS Requirement/Overview
Transition Supply	• Notification to members who have received a transition supply that the current supply was a courtesy and that future fills may not be covered due to plan limitations. Provides member with information on actual drug/utilization rule and member's next steps. • Required to be sent to member within 3 days of transition fill.
Formulary Change Letter	• Notification to members when a drug has been removed from the market, becomes available over the counter, or when there is a change in formulary status.
Excluded Provider/ Pharmacy/ Manufacturer	• Notification to members that their physician, manufacturer or pharmacy is on the federal government's excluded provider list, and that coverage of a prescription must therefore be denied.
Medication Therapy Management	• Ensures that covered Part D drugs prescribed to members are appropriately used by members who meet program criteria.
Precluded Provider	• Notification to members that their provider is on the federal government's preclusion list, and that coverage of a prescription must therefore be denied.

Plan Administration: Transition Supply

Provides important formulary-driven prescription information, including quantity limitations and steps for prior authorization.



EXPRESS SCRIPTS®
Medicare (PDP)

<Return Address_ 1>
<Return Address_ 2>
<Return Address_ 3>
<Return Address_ 4>

<<Letter Date>>

<<First Name>> <<Middle Name>> <<Last Name>>
<<Address 1>>
<<Address 2>>
<<Address 3>>
<<City>>, <<State>> <<Zip>>

Dear <<First Name>> <<Middle Name>> <<Last Name>>:

This letter is to inform you that <Plan Name> has provided you with a temporary supply of the following prescription[s]: <list medication[s] here>.

<This/These> drug[s] <is/are> either not included on our list of covered drugs (called our formulary) or included on the formulary, but subject to certain limits, as described in more detail further below. Our records indicate that you are a [*Insert one or both* <new enrollee of,> or <current enrollee>] affected by formulary changes implemented this year by <Plan Name>. [*Insert for members who do not reside in an LTC facility:* Therefore, in the outpatient setting, <Plan Name> is required to provide at least a 30-day supply unless the prescription is written for less and does not provide for refills.] [*Insert for members who reside in a LTC facility:* As a resident of a long term care facility, <Plan Name> is required to provide at least a 91-day supply and may be up to a 98-day supply, consistent with the dispensing increment, with refills provided, if needed (unless the prescription is written for less).]

It is important that you understand that this is a temporary supply of this drug. Before this supply ends, you should speak to <Plan Name> and/or your physician regarding whether you should change the drug[s] you are currently taking, or request an exception from <Plan Name> to continue coverage of <this/these> drug[s].

If you need assistance in requesting an exception, or for more information about our transition policy, please call <Customer/Member> Service at <Customer Service #>. TTY users should call <TTY number>. We are happy to take your calls from <hours of operations>. Instructions on how to apply for an exception or how to change your current prescription[s] are discussed at the end of the letter.

The following is an explanation of why your drug[s] <is/are> not covered or <is/are> limited under <Plan Name>.

<LT42930A> <CMS Material ID>

[Name of Drug: *<name of drug>*

When	Within 3 days of the transition supply fill
Audience	Only members who fill a prescription that is eligible for a transition supply

Plan Administration: Formulary Change Letter

Express Scripts may change its formulary and then provide notification of such formulary changes to all affected members, such as when a drug is removed because it is deemed unsafe by the Food and Drug Administration (FDA), or when a drug has been removed from the market due to a manufacturer recall.

<Return Address_1>
<Return Address_2>
<Return Address_3>
<Return Address_4>

EXPRESS SCRIPTS®
Medicare (PDP)

<<Letter Date>>

<<First Name>> <<Middle Name>> <<Last Name>>
<<Address 1>>
<<Address 2>>
<<Address 3>>
<<City>>, <<State>> <<Zip>>

Important changes to coverage for certain drugs on your prescription drug plan's formulary

Dear <<First Name>> <<Middle Name>> <<Last Name>>:

We are writing to inform you about changes to your coverage for certain drugs on the <Plan Name> formulary (the list of covered drugs). **Please review the changes below, as they may affect a medication you are taking now.**

If you are still taking a drug listed below, **please ask your doctor about your treatment options and whether an alternative drug* may be right for you.**

Drug: *<<name of drug>>*, *<<strength>>*, *<<dosage>>*
Date of change: *<<effective date>>*
Description of change: <<Formulary Reason Code Table 2013>>
Reason for change: <<Formulary Reason Code Table 2013>>
Alternative drug*: *<<alt_drug_name_1>>*, *<<alt_strength_1>>*
Alternative drug tier†: *<<alt_drug tier_1>>*

Drug: *<<name of drug>>*, *<<strength>>*, *<<dosage>>*
Date of change: *<<effective date>>*
Description of change: <<Formulary Reason Code Table 2013>>
Reason for change: <<Formulary Reason Code Table 2013>>
Alternative drug*: *<<alt_drug_name_1>>*, *<<alt_strength_1>>*
Alternative drug tier†: *<<alt_drug tier_1>>*

Drug: *<<name of drug>>*, *<<strength>>*, *<<dosage>>*
Date of change: *<<effective date>>*
Description of change: <<Formulary Reason Code Table 2013>>
Reason for change: <<Formulary Reason Code Table 2013>>
Alternative drug*: *<<alt_drug_name_1>>*, *<<alt_strength_1>>*
Alternative drug tier†: *<<alt_drug tier_1>>*

LT42738C <Material ID Number>

If the alternative therapy that your doctor recommends require
doctor may request an exception. There are two ways to reque

- Call <Coverage Review> at <Coverage Review #
of Operation>. If you make the request yourself, w
additional information.

or

- Write to:
<Appeals Address_1>
<Appeals Address_2>
<Appeals Address_3>
<Appeals Address_4>

Be sure to include a written statement from your p
your request.

After we get information from your doctor to support your re
within 72 hours of our decision. You can find more informatio
exception or a coverage determination in your *Evidence of Co*

If you have questions, we're here to help
If you have additional questions about your prescription(s), pl
phone number shown on the label of your prescription(s) or c
using the phone numbers on your Member ID card, <Hours/D
/Member Service> is available in English and other languages

Thank you for choosing <Plan Name> for your prescription d
priority, we will continue to update you about any changes to

Sincerely,

<Signature name>
<Signatory title>

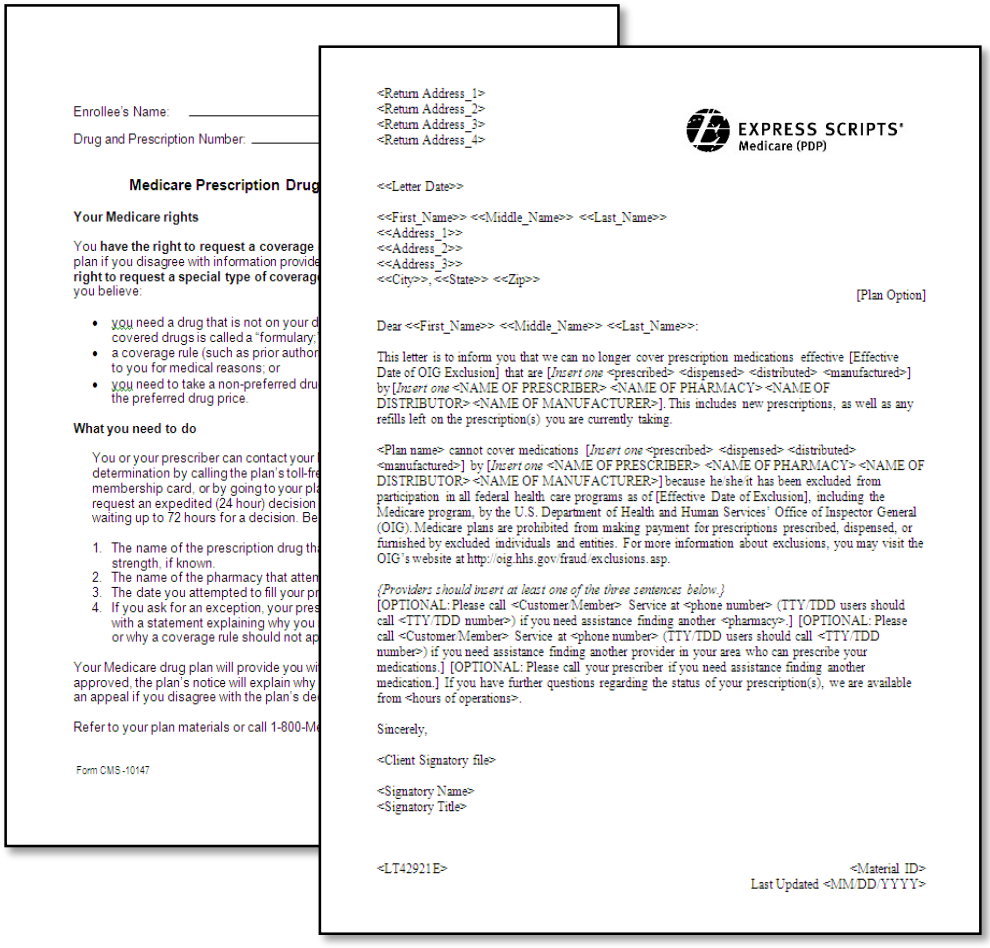
* Alternative drugs are medications that are generally in the s
affected drug. Only your doctor can determine if an alternativ

† Alternative drug tiers represent the copayment or coinsuranc
benefit structure. Actual cost may vary based on your individ
Summary of Benefits for more details.

When	As needed
Audience	Members taking a medication that is affected by the coverage change

Plan Administration: Sanctioned Provider, Pharmacy or Manufacturer Letters

Sent to members to inform them that Express Scripts cannot fill a prescription written by a specific provider, filled at a specific pharmacy or from a specific manufacturer because they are on the Office of Inspector General (OIG) exclusion list.



Enrollee's Name: _____

Drug and Prescription Number: _____

Medicare Prescription Drug

Your Medicare rights

You **have the right to request a coverage** plan if you disagree with information provide **right to request a special type of coverag** you believe:

- you need a drug that is not on your d covered drugs is called a "formulary;"
- a coverage rule (such as prior author to you for medical reasons; or
- you need to take a non-preferred dru the preferred drug price.

What you need to do

You or your prescriber can contact your determination by calling the plan's toll-fr membership card, or by going to your pl request an expedited (24 hour) decision waiting up to 72 hours for a decision. Be

1. The name of the prescription drug th strength, if known.
2. The name of the pharmacy that atten
3. The date you attempted to fill your pr
4. If you ask for an exception, your pres with a statement explaining why you or why a coverage rule should not ap

Your Medicare drug plan will provide you wi approved, the plan's notice will explain why an appeal if you disagree with the plan's de

Refer to your plan materials or call 1-800-M

Form CMS-10147

<Return Address_1>
<Return Address_2>
<Return Address_3>
<Return Address_4>

EXPRESS SCRIPTS® Medicare (PDP)

<<Letter Date>>

<<First_Name>> <<Middle_Name>> <<Last_Name>>
<<Address_1>>
<<Address_2>>
<<Address_3>>
<<City>>, <<State>> <<Zip>>

[Plan Option]

Dear <<First_Name>> <<Middle_Name>> <<Last_Name>>:

This letter is to inform you that we can no longer cover prescription medications effective [Effective Date of OIG Exclusion] that are [*Insert one* <prescribed> <dispensed> <distributed> <manufactured>] by [*Insert one* <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR> <NAME OF MANUFACTURER>]. This includes new prescriptions, as well as any refills left on the prescription(s) you are currently taking.

<Plan name> cannot cover medications [*Insert one* <prescribed> <dispensed> <distributed> <manufactured>] by [*Insert one* <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR> <NAME OF MANUFACTURER>] because he/she/it has been excluded from participation in all federal health care programs as of [Effective Date of Exclusion], including the Medicare program, by the U.S. Department of Health and Human Services' Office of Inspector General (OIG). Medicare plans are prohibited from making payment for prescriptions prescribed, dispensed, or furnished by excluded individuals and entities. For more information about exclusions, you may visit the OIG's website at http://oig.hhs.gov/fraud/exclusions.asp.

{Providers should insert at least one of the three sentences below.}
[OPTIONAL: Please call <Customer/Member> Service at <phone number> (TTY/TDD users should call <TTY/TDD number>) if you need assistance finding another <pharmacy>.] [OPTIONAL: Please call <Customer/Member> Service at <phone number> (TTY/TDD users should call <TTY/TDD number>) if you need assistance finding another provider in your area who can prescribe your medications.] [OPTIONAL: Please call your prescriber if you need assistance finding another medication.] If you have further questions regarding the status of your prescription(s), we are available from <hours of operations>.

Sincerely,

<Client Signatory file>

<Signatory Name>
<Signatory Title>

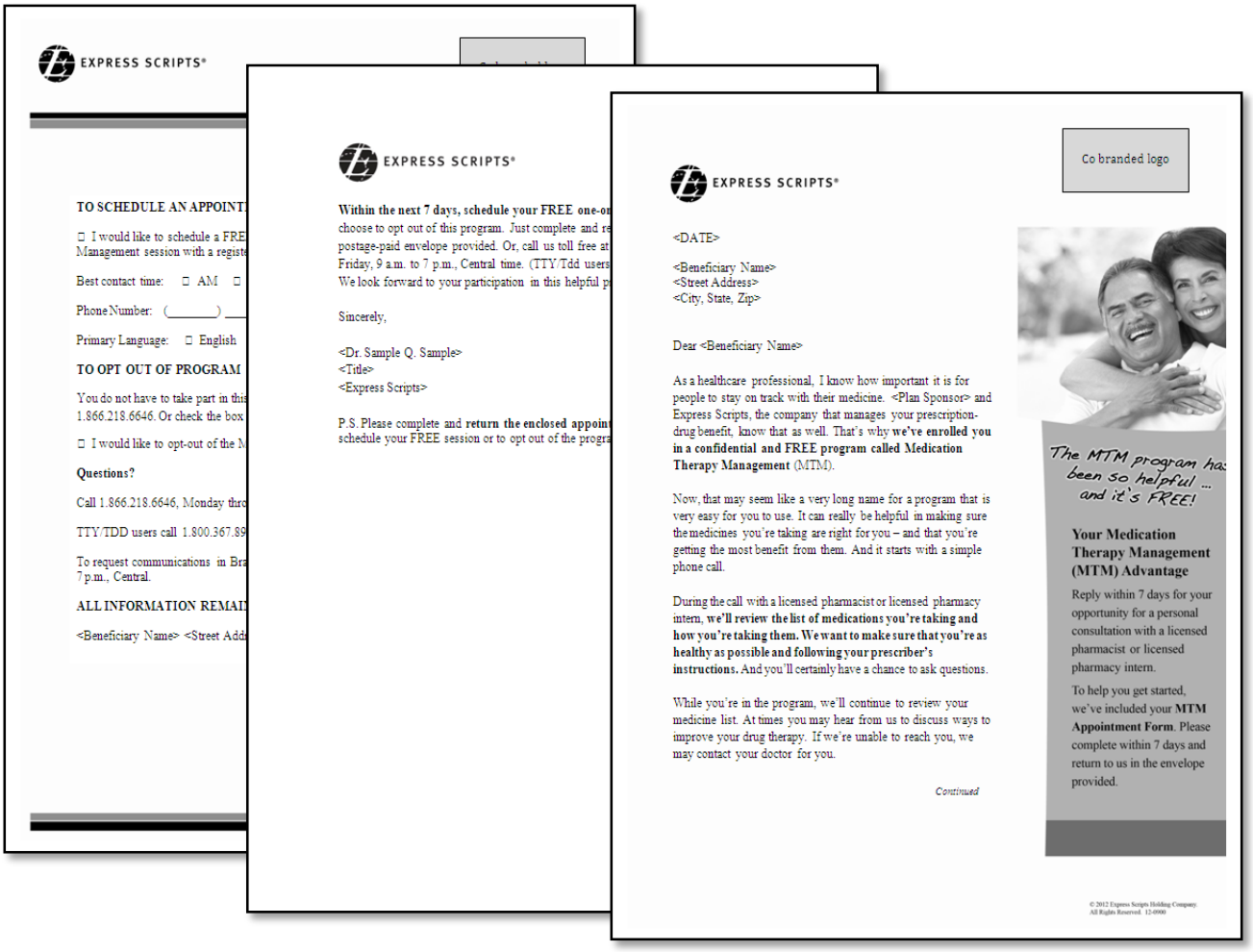
<LT42921E>

<Material ID>
Last Updated <MM/DD/YYYY>

When	Sent monthly
Audience	Members affected by an OIG exclusion

Plan Administration: Medication Therapy Management

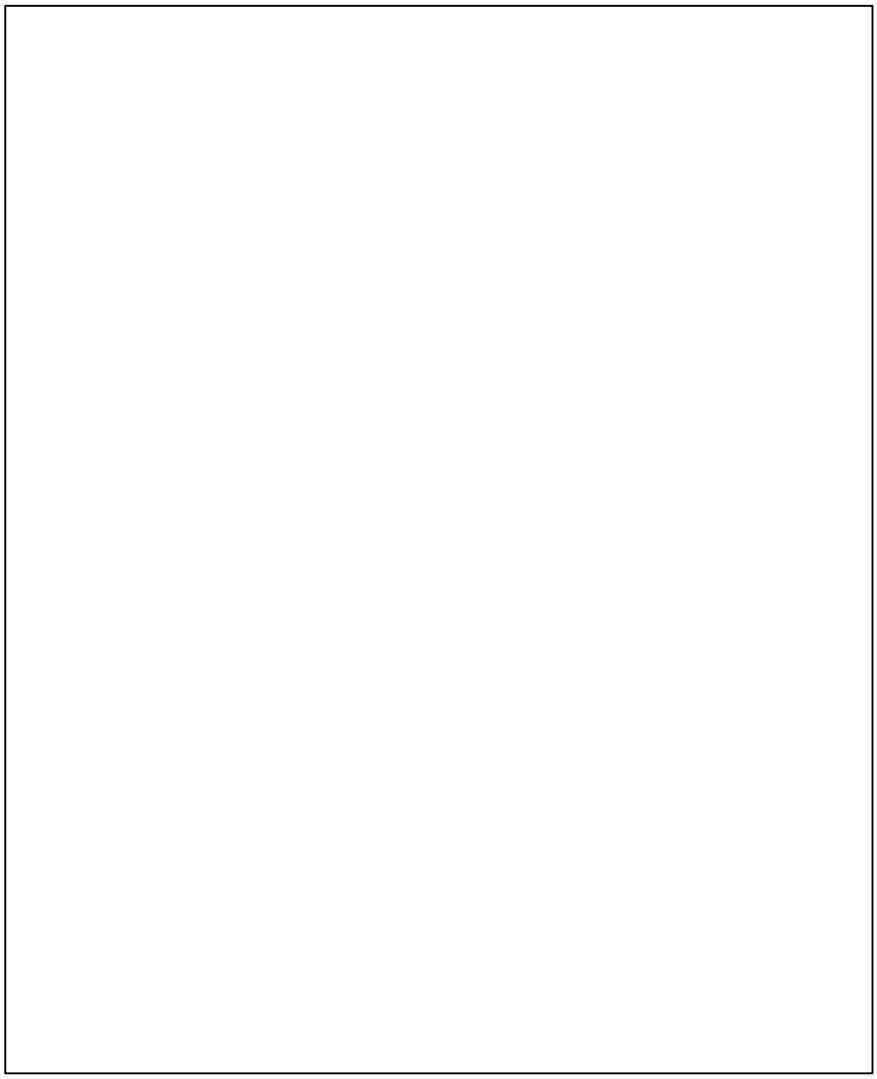
Sent to members who qualify for participation in the Express Scripts MTM program. The initial letter explains the program and asks the member to complete and return an appointment form included in the mailing.



When	As needed, with opt-out program based on targeting criteria
Audience	Members eligible for MTM program
Client Logo	Yes

Plan Administration: Precluded Provider Notice

Sent to members to inform them that Express Scripts cannot fill a prescription because their provider is on the Medicare preclusion list.



When	Sent monthly
Audience	Members affected by Medicare preclusion list

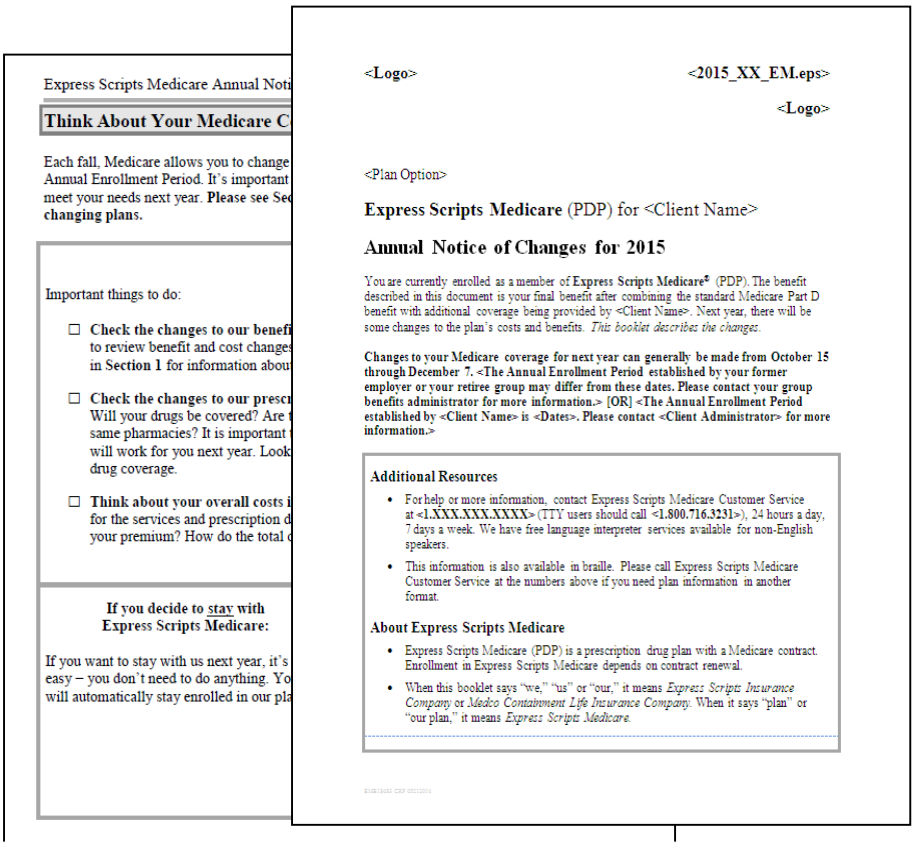
Renewal Communications

Renewal Communications

Mailing	Objective	CMS Requirement
Annual Notice of Changes (ANOC)	• Provide current members with information on all changes to their benefit for the upcoming year to ensure they make educated decisions regarding the upcoming year's prescription drug coverage. • Includes ANOC document, Quick Reference Guide (QRG) and other plan information.	• **For renewing plans only**, the ANOC must be in members' hands 15 days prior to the plan's open enrollment (OE) period for clients who offer multiple plan choices. For clients with single plans or an information-only OE, the ANOC should coincide with the start of the OE period. For clients with no OE period, ANOCs are required to be in homes at least 15 days prior to the new benefit year.
Low-Income Subsidy Communications	• CMS re-assesses low income subsidy qualifications on an on-going basis. Members may be placed in a different low income subsidy level or may lose subsidy in its entirety. • Provide member with their updated cost-sharing amounts for the upcoming plan year.	• Send Extra Help Rider or LIS termination notice (as appropriate) within 30 days of receipt of updated member information.

Renewal Communications: Annual Notice of Changes (ANOC)

Sent annually to existing members and includes benefit information for the upcoming year, Extra Help Rider (if applicable), Quick Reference Guide, and other pertinent plan documents.



Express Scripts Medicare Annual Noti

Think About Your Medicare C

Each fall, Medicare allows you to change
Annual Enrollment Period. It's important
meet your needs next year. **Please see Se**
changing plans.

Important things to do:

- ☐ **Check the changes to our benefi**
  to review benefit and cost changes
  in **Section 1** for information abou
- ☐ **Check the changes to our prescr**
  Will your drugs be covered? Are
  same pharmacies? It is important
  will work for you next year. Look
  drug coverage.
- ☐ **Think about your overall costs i**
  for the services and prescription d
  your premium? How do the total

If you decide to stay with Express Scripts Medicare:

If you want to stay with us next year, it's
easy – you don't need to do anything. Yo
will automatically stay enrolled in our pla

<Logo> <2015_XX_EM.eps>

<Logo>

<Plan Option>

Express Scripts Medicare (PDP) for <Client Name>

Annual Notice of Changes for 2015

You are currently enrolled as a member of **Express Scripts Medicare®** (PDP). The benefit described in this document is your final benefit after combining the standard Medicare Part D benefit with additional coverage being provided by <Client Name>. Next year, there will be some changes to the plan's costs and benefits. *This booklet describes the changes.*

Changes to your Medicare coverage for next year can generally be made from October 15 through December 7. <The Annual Enrollment Period established by your former employer or your retiree group may differ from these dates. Please contact your group benefits administrator for more information.> [OR] <The Annual Enrollment Period established by <Client Name> is <Dates>. Please contact <Client Administrator> for more information.>

Additional Resources

- For help or more information, contact Express Scripts Medicare Customer Service at <1.XXX.XXX.XXXX> (TTY users should call <1.800.716.3231>), 24 hours a day, 7 days a week. We have free language interpreter services available for non-English speakers.
- This information is also available in braille. Please call Express Scripts Medicare Customer Service at the numbers above if you need plan information in another format.

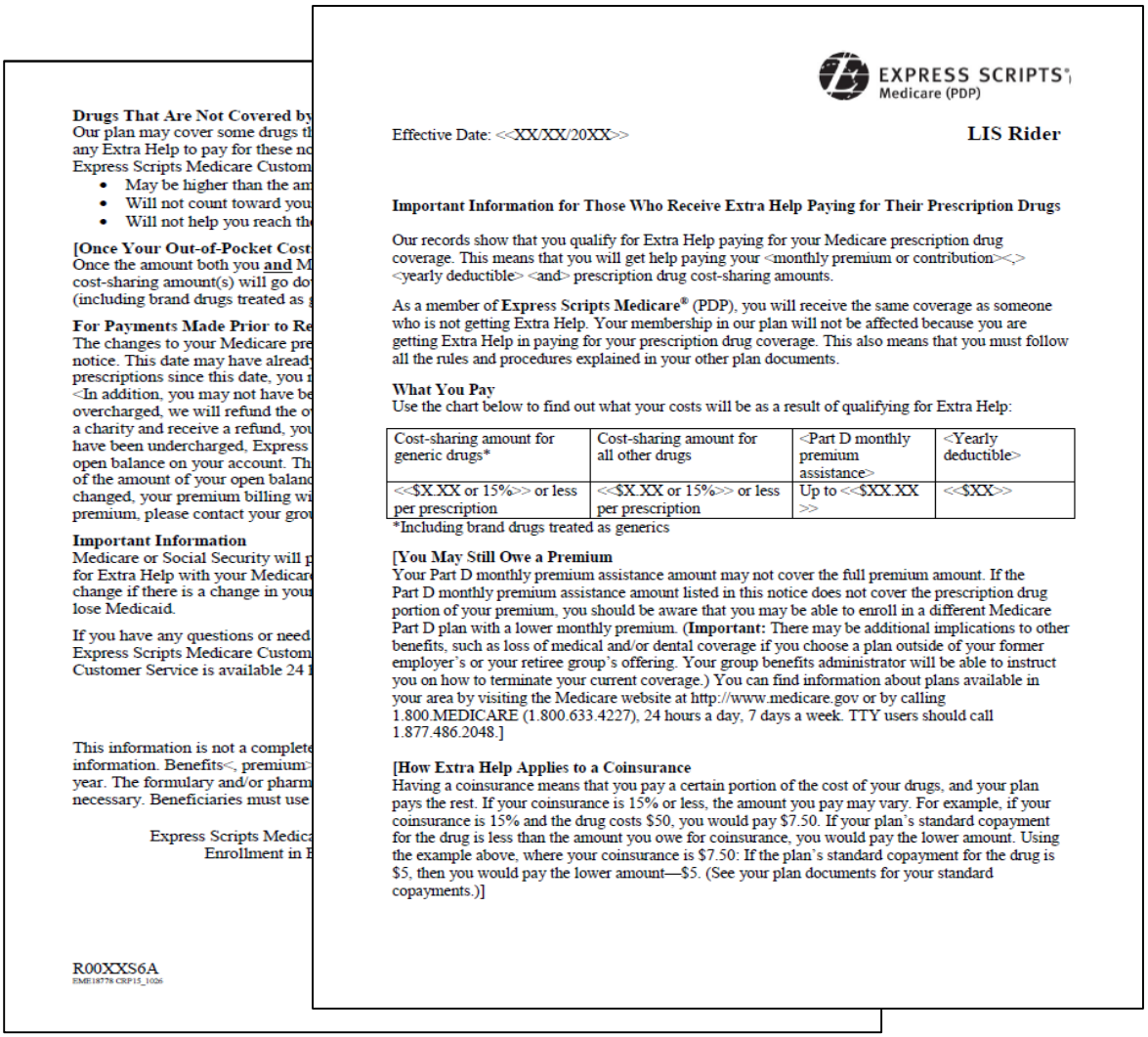
About Express Scripts Medicare

- Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. Enrollment in Express Scripts Medicare depends on contract renewal.
- When this booklet says "we," "us" or "our," it means *Express Scripts Insurance Company* or *Medco Containment Life Insurance Company*. When it says "plan" or "our plan," it means *Express Scripts Medicare*.

When	• The ANOC must be in members' hands 15 days prior to the plan's open enrollment (OE) period for clients who offer multiple plan choices. • For clients who offer an information-only OE, the ANOC should arrive to coincide with the start of the OE period. • For clients with no OE period, ANOCs are required to be in homes a minimum of 15 days prior to the new benefit year.
Audience	All existing members
Client Logo	Yes

Renewal Communications: Extra Help Rider

The Extra Help Rider is sent to members who qualify to receive a low-income subsidy, and explains premium assistance and copayments/coinsurance.



Drugs That Are Not Covered by
Our plan may cover some drugs th
any Extra Help to pay for these no
Express Scripts Medicare Custom

- May be higher than the am
- Will not count toward you
- Will not help you reach th

[Once Your Out-of-Pocket Cost
Once the amount both you **and** M
cost-sharing amount(s) will go do
(including brand drugs treated as

For Payments Made Prior to Re
The changes to your Medicare pre
notice. This date may have alread
prescriptions since this date, you
<In addition, you may not have be
overcharged, we will refund the o
a charity and receive a refund, you
have been undercharged, Express
open balance on your account. Th
of the amount of your open balanc
changed, your premium billing wi
premium, please contact your grou

Important Information
Medicare or Social Security will p
for Extra Help with your Medicar
change if there is a change in you
lose Medicaid.

If you have any questions or need
Express Scripts Medicare Custom
Customer Service is available 24

This information is not a complete
information. Benefits<, premium>
year. The formulary and/or pharm
necessary. Beneficiaries must use

Express Scripts Medica
Enrollment in E

R00XXS6A
EME18778 CRF15_1026

EXPRESS SCRIPTS®
Medicare (PDP)

Effective Date: <<XX/XX/20XX>>

LIS Rider

Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs

Our records show that you qualify for Extra Help paying for your Medicare prescription drug coverage. This means that you will get help paying your <monthly premium or contribution><,> <yearly deductible> <and> prescription drug cost-sharing amounts.

As a member of **Express Scripts Medicare®** (PDP), you will receive the same coverage as someone who is not getting Extra Help. Your membership in our plan will not be affected because you are getting Extra Help in paying for your prescription drug coverage. This also means that you must follow all the rules and procedures explained in your other plan documents.

What You Pay
Use the chart below to find out what your costs will be as a result of qualifying for Extra Help:

Cost-sharing amount for generic drugs*	Cost-sharing amount for all other drugs	<Part D monthly premium assistance>	<Yearly deductible>
<<$X.XX or 15%>> or less per prescription	<<$X.XX or 15%>> or less per prescription	Up to <<$XX.XX >>	<<$XX>>

*Including brand drugs treated as generics

[You May Still Owe a Premium
Your Part D monthly premium assistance amount may not cover the full premium amount. If the Part D monthly premium assistance amount listed in this notice does not cover the prescription drug portion of your premium, you should be aware that you may be able to enroll in a different Medicare Part D plan with a lower monthly premium. **(Important:** There may be additional implications to other benefits, such as loss of medical and/or dental coverage if you choose a plan outside of your former employer's or your retiree group's offering. Your group benefits administrator will be able to instruct you on how to terminate your current coverage.) You can find information about plans available in your area by visiting the Medicare website at http://www.medicare.gov or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.]

[How Extra Help Applies to a Coinsurance
Having a coinsurance means that you pay a certain portion of the cost of your drugs, and your plan pays the rest. If your coinsurance is 15% or less, the amount you pay may vary. For example, if your coinsurance is 15% and the drug costs $50, you would pay $7.50. If your plan's standard copayment for the drug is less than the amount you owe for coinsurance, you would pay the lower amount. Using the example above, where your coinsurance is $7.50: If the plan's standard copayment for the drug is $5, then you would pay the lower amount—$5. (See your plan documents for your standard copayments.)]

When	Sent when a member is identified by CMS as qualified to receive a low-income subsidy or within 30 days of any LIS level changes
Audience	Members who qualify for a low-income subsidy

TAKE THE OPPORTUNITY TO TAKE CONTROL OF YOUR PRESCRIPTION PLAN

TAKE THINGS ONLINE

Create an account on express-scripts.com or the Express Scripts® mobile app.

Manage your prescription plan anytime and anywhere with an online account.
It's simple and easy to get started.

1. **Visit express-scripts.com** and select Register OR download the Express Scripts mobile app for free from your phone's app store and select Register
2. **Enter the requested information,** including your member ID or Social Security number, and create your user name and password
3. **Click or tap Register Now**

Once your account is created, you can:

- Check your order status
- View and print member ID cards
- Enroll in home delivery
- Refill and renew prescriptions
- Enroll eligible prescriptions in automatic refill
- Find your nearest preferred pharmacy
- Set reminders to take your medication

TAKE A SHORTER TRIP TO GET YOUR MEDS

Enroll in home delivery to get your 90-day prescriptions shipped right to your door.

Requesting to get your medications delivered to your home from Express Scripts® Pharmacy is simple and convenient.
First, log in to express-scripts.com (if you haven't already registered, make sure to have your member ID or SSN).

If you are enrolling a new prescription…

Contact your doctor and ask them to e-prescribe a 90-day prescription directly to Express Scripts

OR send a request by selecting "Forms" or "Forms & Cards" from the "Benefits" menu, print a mail order form and follow the mailing instructions

If you are enrolling a current prescription…

Transfer retail prescriptions to home delivery by **clicking "Add to Cart"** for eligible prescriptions and check out. You can also **refill and renew** prescriptions.
We'll contact your doctor and take care of the rest.

Check **Order Status** to track the shipping of your prescriptions. After we receive your prescription from your doctor, you will receive your medication within 7 days.[1]

TAKE A BREAK FROM BRAND NAMES

Ask about switching to a generic medication to save money on your prescriptions.

By not looking for the best deal on your prescription drugs, you may end up paying more than you should for your medications.

The easiest—and safest—way to save money on prescriptions is to ask for a generic, which typically costs less because the manufacturer did not have to conduct the initial research or studies that the branded drug did.

Generics fall into two categories:

Direct chemical equivalent – a drug that has the same active ingredient as its brand-name counterpart

Therapeutic alternative – a drug that may not be chemically equivalent to the brand, but has the same therapeutic or treatment effect

Direct chemical equivalents are practically identical to the branded drug, while therapeutic alternatives are part of the same family.

Is there a generic for your medication? You can ask…

Your health care provider. Check with your doctor or nurse if there's a generic for any medication you're prescribed.

Your pharmacist. Before getting a prescription filled, refilled or renewed, ask your pharmacist if there's a generic alternative.

Express Scripts. You can review your prescriptions and specific generics savings opportunities at **express-scripts.com**.

DID YOU KNOW

All generics must adhere to strict guidelines before the FDA will approve their use and are the same as a brand-name medication in dosage, safety, effectiveness, strength, stability and quality.

For additional information on how to take control of your prescription plan or any other questions about your account or coverage, visit **express-scripts.com**, **download the Express Scripts mobile app** or **call the Member Services number** on the back of your member ID card.

EXPRESS SCRIPTS®

1 Over 85% of members receive their medications within 7 days. Longer delivery times may be due to additional correspondence needed with prescribers, medication availability and/or delivery times from the shipping vendor.

2022 Benefit Fair
Give-aways & Raffle Items

GIVE-AWAY ITEMS

Pen

Pill Case

RAFFLE ITEMS

Igloo Yukon
Box Cooler

RFID 15”
Computer Backpack

Thor Copper
Bottle

Field & Co.
Sherpa Blanket

Member Communication Samples

Employer Group Waiver Plans

Contents

PRE-NOTIFICATION LETTER SAMPLE

Express Scripts
P.O. Box 66562
St. Louis, MO 63166-6562

<ESI/client logo>

<<First Name>> <<Middle Initial>> <<Last Name>>
<<Address 1>>
<<Address 2>>
<<Address 3>>
<<City, ST ZIP>>

TIME SENSITIVE—OPEN IMMEDIATELY

<<Month DD, YYYY>>

*****Important information*****
Effective <<January 1, 2022>>, you will be enrolled in prescription drug coverage through **Express Scripts Medicare** (PDP)* for <Client Name>

Dear <<First Name>> <<Middle Initial>> <<Last Name>>:

<Option 1: Outside ESI book and new to EGWP:
Beginning <<January 1, 2022>>, Express Scripts will administer your prescription drug coverage through the Medicare Part D program. You will be enrolled in **Express Scripts Medicare®** (PDP)* for <Client Name> unless you notify <Client Name> within 21 days of receiving this letter that you do not want to be enrolled in this plan. (However, Express Scripts Medicare may need to contact you for more information in order to complete your enrollment. Be sure to open and review any future communications you may receive from Express Scripts Medicare and respond in a timely manner if a reply is requested.)>
<Option 2: Outside ESI book and moving EGWP to EGWP:
Beginning <<January 1, 2022>>, <Client Name>'s prescription drug coverage will move to **Express Scripts Medicare®** (PDP)* for <Client Name>. If you do not want to be automatically enrolled in this plan, you must notify <Client Name> within 21 days of receiving this letter. (However, Express Scripts Medicare may need to contact you for more information in order to complete your enrollment. Be sure to open and review any future communications you may receive from Express Scripts Medicare and respond in a timely manner if a reply is requested.) **You may receive a notice from your current plan regarding an end date for your prescription drug coverage—this is a required communication. Please be aware that <Client Name> will continue to provide your prescription drug coverage, which will be administered by Express Scripts.>**
<Option 3: ESI RDS conversion:
Beginning <<January 1, 2022>>, <Client Name> will be sponsoring your prescription drug coverage through the Medicare Part D program. This coverage will continue to be administered by Express Scripts. You will be enrolled in **Express Scripts Medicare®** (PDP)* for <Client Name> unless you notify <Client Name> within 21 days of receiving this letter that you do not want to be enrolled in this plan. (However, Express Scripts Medicare may need to contact you for more information in order to complete your enrollment. Be sure to open and review any future communications you may receive from Express Scripts Medicare and respond in a timely manner if a reply is requested.)>

* PDP stands for prescription drug plan.

<LP0XXX2A>

<This new plan is comparable to your current plan and will offer better coverage than a standard Medicare Part D plan.> This prescription drug coverage is considered **creditable coverage,** which means it is at least as good as the standard Medicare prescription drug coverage.

Who is eligible for this plan?

You are eligible for this plan if you are entitled to Medicare Part A and/or are enrolled in Medicare Part B, live in the plan's service area, are a U.S. citizen or are lawfully present in the United States and are eligible for benefits from <Client Name>.

Does enrollment in this plan impact any other coverage I may already have?

Enrollment in this plan may cancel your enrollment in the following types of plans:

- another Medicare Part D plan
- a Medicare Advantage (MA) Plan with prescription drug coverage (MA-PD)
- a Medicare Advantage Plan not sponsored by <Client Name>

You may, however, be enrolled in this plan and an MA-only plan if it has been coordinated through your employer. Please contact your group benefits administrator if you have questions about other plan types and the impact your enrollment in this plan may have.

What should I do if I don't want to join Express Scripts Medicare?

Your enrollment in Express Scripts Medicare will occur automatically. However, you can request that you not be enrolled by <insert clear instruction for opting out, including telephone numbers and days/hours of operation>.

What happens if I don't join Express Scripts Medicare?

Important: If you decide not to be enrolled in this plan, <insert consequences for opting out of group plan, such as not being able to re-enroll, or that other benefits will be impacted>. Keep in mind that if you leave our plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

If you choose not to be enrolled in this plan, you can join a new Medicare prescription drug plan or Medicare health plan outside of your former employer's plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. You can, however, join or leave a plan at any time if Medicare decides that you need Extra Help with paying the plan costs. If Medicare decides that you no longer need Extra Help, you will have two months to make changes after Medicare notifies you of its decision. You can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week for assistance. TTY users should call 1.877.486.2048.

Do I need to do anything if I am currently taking a drug that requires prior authorization?

You may currently have a prescription for which you have obtained a prior authorization or prior approval from your current plan. If your medication also requires a prior authorization under your new plan, you may need to obtain a new approval. In some cases, existing authorizations from your current plan may not be carried over into your new plan. Call Express Scripts Medicare Customer Service at the numbers listed at the end of this letter to determine if your drug requires a prior authorization. If you require a new approval, call Customer Service after your membership in the plan becomes effective to start the prior authorization process.

<Am I still able to use VA pharmacies?
VA pharmacies are not permitted to be included in Medicare Part D pharmacy networks. If you are eligible for VA benefits, you can still use VA pharmacies under those benefits. However, the cost of those medications and what you pay out of pocket will not count toward your Medicare Part D drug spend or out-of-pocket cost accumulators. Review your new plan benefit against your VA benefit to determine the best option for you. You may choose to use your VA benefit at your VA pharmacy or to transfer your prescription(s) to an Express Scripts Medicare network pharmacy.>

When will I receive my new member ID card and other plan materials?
You will receive a Welcome Kit from Express Scripts prior to your effective date. In the meantime, please review and save this letter and the enclosed *Benefit Overview,* which provides details about your new prescription drug coverage.

Your Welcome Kit will include your **new** Medicare prescription drug plan member ID card. You should use this card beginning with the effective date of your prescription drug coverage when filling prescriptions. <(Do not discard your medical coverage ID card; you should continue to use your medical card for any other services.)> The Centers for Medicare & Medicaid Services (CMS) requires that we send you these materials upon your enrollment in a Medicare prescription drug plan.

Note: Because Medicare is an individual benefit, you and your covered Medicare-eligible spouse will each have a unique member ID number and prescription drug plan member ID card. In addition, you will each receive separate communications from Express Scripts Medicare.

What happens if I have a late enrollment penalty?
Express Scripts will send you notification if CMS has identified you as having to pay a late enrollment penalty (LEP). If you disagree with your LEP, you can ask Medicare to reconsider its decision. The notification from Express Scripts will explain your right to a reconsideration of the LEP. <<Client Name> may choose to cover the LEP on its members' behalf.>

Whom should I contact if I have questions?
If you have any questions about the new plan, you may contact Express Scripts Medicare Customer Service at **<1.XXX.XXX.XXXX> <**beginning <OE start date –or- January 1>. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1.800.716.3231.**

Thank you.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

Other pharmacies are available in our network.

Express Scripts Medicare is a Medicare prescription drug plan, which is in addition to your coverage under Medicare Part A and/or Part B. Your enrollment in this plan doesn't affect your coverage under Medicare Part A and/or Part B. It is your responsibility to inform Express Scripts Medicare of any prescription drug coverage that you have or may get in the future. You can be in only one Medicare prescription drug plan at a time.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. <Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.>

By joining this Medicare prescription drug plan, you acknowledge that Express Scripts Medicare can release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that Express Scripts Medicare can release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The Centers for Medicare & Medicaid Services must approve Express Scripts' plan each year. You can continue to get Medicare coverage as a member of this plan only as long as both Express Scripts and <Client Name> choose to continue to offer this plan, and CMS renews its approval of Express Scripts' plan.

WELCOME LETTER SAMPLE

ID No.: <<MemberID>>
Issuer: (80840) 9151014609
RxGrp: <<Card-RxGrp-Logic>>
RxBin: <<RuleBIN>>
RxPCN: <<RulePCN>>

<<RulePlan_Option_Text>>

<<LetterDate>>

Your Effective Date: <<EOCRiderEffDt>>

Dear <<Salutation>>:

Welcome to **Express Scripts Medicare**® (PDP) for <Client Name>. Medicare has approved your enrollment in this plan beginning with the effective date provided above.

How will my coverage work?
As of your effective date, you should begin using Express Scripts Medicare network pharmacies to fill your prescriptions. Please present the member ID card included with this mailing to your pharmacist. If you use an out-of-network pharmacy (except in an emergency), Express Scripts Medicare may not pay for your prescriptions. For more information or to find network retail pharmacies in your area, visit our website at **express-scripts.com** or call Customer Service at the numbers below.

<What is my plan premium and how do I pay it?
For more information about your plan premium and ways to pay it, please contact [your group benefits administrator].>

What if I have more questions?
Please see the information on the other side of this letter. If you have additional questions, please contact Express Scripts Medicare at **<1.XXX.XXX.XXXX>.** Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1.800.716.3231.** You can also visit Express Scripts on the Web at **express-scripts.com**. For more information on resources available on the Web, review the information in the enclosed *Quick Reference Guide.*

Sincerely,

Express Scripts Medicare

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

Other pharmacies are available in our network.

L00XXX2A

Additional Information About Your Coverage

What is the Extra Help program?
People with limited incomes may qualify for Extra Help to pay for their Medicare prescription drug costs. If you are eligible to receive Extra Help, Medicare could pay up to seventy-five (75) percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles and copayments. For more information about Extra Help, contact your local Social Security office or call Social Security at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778.

If the Centers for Medicare & Medicaid Services (CMS) has already identified you as qualifying for Extra Help, we have enclosed a separate insert in this package that will provide you with details on your plan costs.

If you think you qualify for Extra Help with your Medicare prescription drug costs, but you don't have or can't find proof, please contact Express Scripts Medicare at the phone numbers on the previous page.

What if I have a Medigap policy (other than through <Client Name>)?
If you have a Medigap (Medicare Supplement Insurance) policy that includes Medicare prescription drug coverage, you must contact your Medigap issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap issuer for details.

Will I pay a late enrollment penalty (LEP)?
The LEP is an amount you may be charged for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare prescription drug plan when they are first eligible or to keep other prescription drug coverage that meets Medicare's minimum standards. You may owe an LEP if you didn't join a Medicare prescription drug plan when you were first eligible for Medicare Part A and/or Part B, and: You didn't have other prescription drug coverage that met Medicare's minimum standards, **or** you had a break in coverage of at least 63 days. If we determine that you owe an LEP or have an existing penalty that needs to be adjusted, we will notify you of the change.

WELCOME KIT QUICK REFERENCE GUIDE (QRG) SAMPLE

Your Prescription Drug Plan Materials

We are pleased to provide you with your **Express Scripts Medicare**® (PDP) plan materials for the 2022 plan year. Please promptly review the enclosed materials to become familiar with your benefit. The following plan materials are enclosed in this package:

- **Quick Reference Guide**
  Use this document to find important contact information for your plan and instructions on how to fill a prescription at a network retail pharmacy or by using our home delivery pharmacy.
- **Prescription ID Card (Member ID Card)**
  Detach and use your member ID card to fill prescriptions beginning with the effective date of your coverage listed on the enclosed Welcome Letter.
- **Benefit Overview**
  This document provides a summary of your benefits and costs for this plan.
- **Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs ("LIS Rider")**
  If you qualify for a low-income subsidy through the Extra Help program, this document will help you understand the amount of assistance you will be receiving for the 2022 plan year.
- **Notice of Privacy Practices**
  We care about your privacy. We follow applicable state and federal rules relating to the protection of health information. This notice explains how we use information about your health.

Express Scripts Medicare Customer Service Call here to find out in advance if a drug is covered or to ask other general questions.
Call: <1.XXX.XXX.XXXX>
TTY: 1.800.716.3231
Hours: 24 hours a day, 7 days a week

<Employer/Benefits Admin Name>
Write: <Employer/Benefits Administrator> <Address 1> <Address 2>
Call: <1.XXX.XXX.XXXX>
TTY: <1.XXX.XXX.XXXX>
Hours: <TBD> <TBD>

Quick Reference Guide

Grievance Contact Information
Use this contact information to file a grievance.

Write:	Express Scripts Medicare Attn: Grievance Resolution Team P.O. Box 3610 Dublin, OH 43016-0307	**Call:** **TTY:** **Fax:** **Hours:**	<1.XXX.XXX.XXXX> 1.800.716.3231 1.614.907.8547 24 hours a day, 7 days a week

Initial Coverage Reviews
Use this contact information if you need an initial coverage decision for a medication that must be approved before the prescription can be filled at a participating retail or home delivery pharmacy, or to remove or change a restriction on a specific medication.

Write:	Express Scripts Attn: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571	**Call:** **TTY:** **Fax:** **Hours:**	1.844.374.7377 (1.844.ESI.PDPS) 1.800.716.3231 1.877.251.5896 24 hours a day, 7 days a week

Appeals Contact Information
Use this contact information if you need to file an appeal because your coverage review was denied or because your request to remove or change a restriction on a medication was denied.

Write:	Express Scripts Attn: Medicare Appeals P.O. Box 66588 St. Louis, MO 63166-6588	**Call:** **TTY:** **Fax:** **Hours:**	1.844.374.7377 (1.844.ESI.PDPS) 1.800.716.3231 1.877.852.4070 24 hours a day, 7 days a week

Paper Claim Submission
Mail requests to receive payment for medications already received with receipts to:

Express Scripts
Attn: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

To obtain a Direct Claim Form:
Download from our website, **express-scripts.com**, in the Medicare Resources Center found in the Benefits menu, or call Customer Service.

The Direct Claim Form is not required, but it will help us process the information faster. It's a good idea to make a copy of all of your receipts for your records. You can fax us your request for payment 24 hours a day, 7 days a week to **1.608.741.5483.**

Useful Information

Visit Express Scripts on the Web at express-scripts.com
If you have not already registered on our website, we encourage you to do so. The information you will need to complete registration can be found on your member ID card.

Our website provides a number of resources and tools, including the ability to:

- View a list of the medications you take
- Refill your prescriptions with just a click
- Find network pharmacies near you
- Request prescription renewals
- View a financial summary of your prescription expenses
- View up-to-date coverage information
- View/print plan forms

You can also view similar information on our mobile app, which you can download for free by searching for "Express Scripts" in your mobile device's app store. Log in to view your virtual ID card and other tools, similar to what you can find on our website.

How to fill a prescription at a network pharmacy
To fill your prescription at a network retail pharmacy, you must show your member ID card. If you do not have your member ID card with you when you are at the pharmacy, you should ask the pharmacist to use Medicare's inquiry system to check your eligibility and membership status with your plan. If the pharmacy is unable to confirm your eligibility, you will have to pay the full cost of the prescription (rather than just paying your copayment or coinsurance). You can request reimbursement of the plan's share of the cost by submitting a paper claim to Express Scripts Medicare. You can get a paper claim form by visiting our website or by calling Customer Service.

How to fill a prescription through our home delivery pharmacy service, Express Scripts® Pharmacy
You can use Express Scripts® Pharmacy, our home delivery pharmacy service, to fill prescriptions for most drugs on the Drug List. Home delivery is most appropriate for drugs that you take on a regular basis for a chronic or long-term medical condition. Usually, a home delivery pharmacy order from Express Scripts® Pharmacy will get to you within 10 days. Some drugs that cannot be purchased through our home delivery service include medications with limited distribution and compound medications. It's also more appropriate to use a network retail pharmacy for drugs used for a short period of time (1 month or less) and drugs needed immediately for the treatment of a severe medical condition. Other home delivery pharmacies are available in our network and they may have their own policies regarding prescriptions by mail. We suggest that you contact those pharmacies directly for any requirements they may have.

This plan may also provide coverage for specialty medications. If you require specialty medications to treat complex conditions, such as cancer, hepatitis C, hemophilia and multiple sclerosis, and want to use home delivery, consider asking your prescriber to send those prescriptions directly to Accredo, the Express Scripts specialty pharmacy. For more information, please have your prescriber visit www.accredo.com for referral forms, contact information by therapy and e-prescribing instructions.

See the following page for instructions for filling a prescription using our home delivery service by mail, electronically and fax. To get order forms and information, please visit our website or call Customer Service. Please note that you must use an in-network home delivery pharmacy.

Prescription drugs that you get through any out-of-network home delivery pharmacies may not be covered. If your doctor sends us a prescription on your behalf, Express Scripts Medicare may contact you to see if you want the medication filled and shipped immediately. If you receive a prescription by mail that you don't want, and you weren't contacted to see if you wanted it before it shipped, contact Customer Service because you may be eligible for a refund.

To fill a prescription through Express Scripts® Pharmacy by mail:

1. Ask your doctor to write a new prescription for up to a 90-day supply of medication, plus refills (as appropriate).
2. Complete a home delivery order form. Choose a convenient payment method. You may pay by check, money order, major credit or debit card, MasterPass or PayPal. If you prefer to pay by credit or debit card, you may also want to join our automatic payment program by simply keeping your credit or debit card information on file with us.
3. Mail the new prescription(s), along with a completed home delivery order form and the appropriate payment.
4. To obtain home delivery forms, or if you have questions, please call Customer Service. You can also access home delivery order forms online at **express-scripts.com.**

To fill a prescription through Express Scripts® Pharmacy electronically or by fax:

1. Ask your doctor to write a new prescription for up to a 90-day supply of medication, plus refills (as appropriate). Give your doctor your member ID number, which is located on the front of your member ID card.
2. If your doctor needs instructions on faxing your prescription to our home delivery pharmacy, ask him/her to call **1.888.327.9791.**
3. Your doctor can send your prescription electronically to Express Scripts® Pharmacy or fax it to **1.800.837.0959.**

ID CARD SAMPLE

Express Scripts
P.O. Box 14235
Lexington, KY 40512

First-Class Mail Enclosed

Return Service Requested

1 0
123456789123//6056//XXXX//LSP1527//XXXX//XXXXXXXXXX
//00//11139//1234////20110516 CID PMM-MWK

JOHN Q. SAMPLE
<ADDRESS LINE 1>
<ADDRESS LINE 2>

EXPRESS SCRIPTS®
Medicare (PDP)

IMPORTANT

Your Express Scripts Medicare® (PDP) member prescription ID card is below. Please detach and place in your wallet.

Note: Your member ID number is indicated as "ID No" on your card.
Please have this number available when you call Express Scripts with any inquiries.

Detach Card →

EXPRESS SCRIPTS®
Medicare (PDP)

Prescription ID Card

RxBIN	XXXXXX
RxPCN	MEDDPRIME
RxGrp	XXXXXXX
Issuer (80840)	9151014609
ID No.	XXXXXXXXXXX
Name	JOHN Q. SAMPLE
Issued	XX/XX/XXXX

MedicareRx
Prescription Drug Coverage

CMS-S5660-801

← **Detach Card**

T0USXS6W
00000001010100

Member Customer Service:	1.XXX.XXX.XXXX
TTY Users:	**1.800.716.3231**
Web:	**www.Express-Scripts.com**

Pharmacist Use Only:	**1.800.922.1557**

BENEFIT OVERVIEW SAMPLE

EVERNORTH℠

Benefit Overview

Express Scripts Medicare® (PDP) for <Client Name>

YOUR 2022 PRESCRIPTION DRUG PLAN BENEFIT

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

Plan Premium

<Your group benefits administrator will tell you the amount that you pay for your plan. If you have any questions, please contact your group benefits administrator.>

Deductible stage

<You pay a $<XXX> yearly deductible.>

Initial Coverage stage

<After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reach $4,430:>

Tier	Retail One-Month <(31-day)> Supply	Retail Three-Month (90-day) Supply	Express Scripts® Pharmacy Home Delivery* Three-Month (90-day) Supply
Tier 1: **Generic Drugs**	<$XX copayment>	<$XX copayment>	<$XX copayment>
Tier 2: **Preferred Brand Drugs**	<$XX copayment>	<$XX copayment>	<$XX copayment>
Tier 3: **Non-Preferred Drugs**	<X% coinsurance>	<X% coinsurance>	<X% coinsurance>
Tier 4: **Specialty Tier Drugs**	<X% coinsurance>	<X% coinsurance>	<X% coinsurance>

If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

*Your cost-sharing amount may differ from the information shown in this chart if you use a home delivery pharmacy other than Express Scripts® Pharmacy. Other pharmacies are available in our network.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through Express Scripts® Pharmacy. There is no charge for standard shipping.

	Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more information.
Coverage Gap stage	<After your total yearly drug costs reach $4,430, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach $7,050.>
Catastrophic Coverage stage	<After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $7,050, you will pay **the greater of 5% coinsurance <u>or</u>:** • a $3.95 copayment for covered generic drugs (including drugs treated as generics) • a $9.85 copayment for all other covered drugs.>

Long-Term Care (LTC) Pharmacy
If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one-month supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage
You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more details.

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- You are eligible for this plan if you are entitled to Medicare Part A and/or are enrolled in Medicare Part B, are a U.S. citizen or are lawfully present in the United States, and are eligible for benefits from <Client Name>.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **express-scripts.com/pharmacies**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.

- Beginning October 15, 2021, you can access your plan's 2022 list of covered drugs by visiting our website at **express-scripts.com/documents**.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- <If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.>
- <If you request <a formulary/an> exception for a drug and Express Scripts Medicare approves the exception, you will pay the cost-sharing amount set by your plan for that drug.>
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party<, even if your Medicare Part D plan premium is $0>.
- <Add correct EOB TEXT located in the Instructions.>

For an explanation of your plan's rules, contact Express Scripts Medicare Customer Service at the numbers on the back of this document or review the *Evidence of Coverage* (EOC) by visiting our website, **express-scripts.com/documents**. You can request a copy of the EOC by calling Express Scripts Medicare Customer Service.

Does my plan cover Medicare Part B or non–Part D drugs?
<Express Scripts Medicare does not cover drugs that are covered under Medicare Part B as prescribed and dispensed, or any other non–Part D drugs. Generally, we only cover drugs, vaccines, biological products and medical supplies associated with the delivery of insulin that are covered under the Medicare prescription drug benefit (Part D) and that are on our formulary.>

Will my income affect my cost for Medicare Part D coverage?
Some people may pay an extra amount called the Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA) because of their yearly income. If you have to pay an extra amount, Social Security – *not your Medicare plan* – will send a letter telling you what the extra amount will be and how to pay it. If you have any questions about this extra amount, contact Social Security at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778.

Read the *Medicare & You* 2022 handbook.
The *Medicare & You* handbook has a summary of Original Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. You can get a copy at the Medicare website (https://www.medicare.gov) or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

<Express Scripts Medicare Customer Service

1.XXX.XXX.XXXX

24 hours a day, 7 days a week

We have free language interpreter services available for non-English speakers.

TTY: **1.800.716.3231**

You can also visit us on the Web at **express-scripts.com**.>

This information is not a complete description of benefits. Call Express Scripts Medicare at the phone numbers above for more information.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

This document may be available in braille. Please call Customer Service at the phone numbers listed above for assistance.

<For questions about< premiums,> enrollment and eligibility, please contact TKTKTKTKTK at **1.XXX.XXX.XXXX.** Hours of operation are TKTKTKTK.>

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

EXTRA HELP RIDER SAMPLE

Effective Date: <<XX/XX/20XX>>

LIS Rider

Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs

Our records show that you qualify for Extra Help to pay for your Medicare prescription drug coverage, such as your <monthly premium or contribution><,> <yearly deductible> <and> cost-sharing amounts.

As a member of **Express Scripts Medicare**® (PDP), you will receive the same coverage as someone who is not getting Extra Help. Although you may pay less for this coverage, you must follow all the rules and procedures explained in your other plan documents.

What You Pay
Use the chart below to find out what your prescription drug costs will be<,> <and> <how much premium assistance you will receive> <and how much your deductible will be> as a result of qualifying for Extra Help. If the actual cost of the drug is lower than the values you see in the chart below, you will pay the lower amount(s).

Cost-sharing amount for generic drugs*	Cost-sharing amount for all other drugs	<Part D monthly premium assistance>	<Yearly deductible>
<<$X.XX or 15%>> or less per prescription	<<$X.XX or 15%>> or less per prescription	Up to <<$XX.XX>>	<<$XX>>

*Including drugs treated as generics

[**You May Still Owe a Premium**
Your Part D monthly premium assistance amount may not cover the full premium amount. If the Part D monthly premium assistance amount listed in this notice does not cover the prescription drug portion of your premium, you should be aware that you may be able to enroll in a different Medicare Part D plan with a lower monthly premium. (**Important:** There may be additional implications to other benefits, such as loss of medical and/or dental coverage if you choose a plan outside of your former employer's or your retiree group's offering. Please contact your group benefits administrator before making a change.) You can find information about plans available in your area by visiting the Medicare website at https://www.medicare.gov or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.]

[How Extra Help Applies to a Coinsurance
Having a coinsurance means that you pay a certain portion of the cost of your drugs, and your plan pays the rest. If your coinsurance is 15% or less, the amount you pay may vary each time you fill a prescription. For example, if your coinsurance is 15% and the drug costs $50, you would pay $7.50. If your plan's standard copayment for the drug is less than the amount you owe for coinsurance, you would pay the lower amount. Using the example above, where your coinsurance is $7.50: If the plan's standard copayment for the drug is $5, then you would pay the lower amount—$5. (See your plan documents for your standard copayments.)]

Drugs That Are Not Covered by Medicare Part D
Our plan may cover some drugs that are not normally covered by Medicare Part D. You will not get any Extra Help to pay for these non–Part D drugs. To find out which drugs this applies to, contact Express Scripts Medicare Customer Service. The amount you owe for these drugs:

- May be higher than the amounts outlined in this notice
- Will not count toward your deductible, if you have one
- Will not help you reach the Catastrophic Coverage stage

[Once Your Out-of-Pocket Costs Reach $7,050, Your Copayment Will Go Down
Once the amount both you **and** Medicare pay (as the Extra Help) reaches $7,050 in a year, your cost-sharing amount(s) will go down to <**LIS2-4**: $0 per prescription/**LIS5-9:** $3.95 for generic drugs (including drugs treated as generics) and $9.85 for all other drugs. If your plan's cost-sharing amounts in the Catastrophic Coverage stage are lower, you will pay the lower amount>.]

For Payments Made Prior to Receiving This Notice
The changes to your Medicare prescription drug costs begin as of the effective date at the top of this notice. This date may have already passed when you get this notice. If you have filled any prescriptions since this date, you may not have been charged the appropriate amount at the pharmacy. If you have been overcharged, we will refund the overpayment to you. If you have been undercharged, Express Scripts will send you a notification informing you that you have an open balance on your account. This notification is not a request for payment; rather, it is to notify you of the amount of your open balance, which will be held against future refunds. <If you were charged a premium since the effective date at the top of this notice, your premium billing may be adjusted accordingly. For further information about your plan premium, please contact your group benefits administrator.> Please note: If you have received assistance from a charity and receive a refund, you should work directly with the charity to refund its portion.

Important Information
Medicare or Social Security will periodically review your eligibility to make sure that you still qualify for Extra Help with your Medicare prescription drug plan costs. Your eligibility for Extra Help might change if there is a change in your income or resources, if you get married or become single or if you lose Medicaid.

If you have any questions or need this notice in a different format (such as braille), please call the Express Scripts Medicare Customer Service number located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

ANNUAL NOTICE OF CHANGES SAMPLE

Express Scripts Medicare (PDP) for <Client Name>

Annual Notice of Changes Plan Materials for 2022

Enclosed are your **Express Scripts Medicare**® (PDP) renewal materials for the 2022 plan year. Please remember that your renewal in this plan is automatic—no action is required to continue your membership for 2022. Please promptly review the enclosed materials to become familiar with the changes to your benefit.

The following renewal materials are enclosed:

- **Quick Reference Guide**
  Use this document to find important contact information for your plan.

- **Annual Notice of Changes**
  Use this document to see a summary of any changes to your benefits and costs for the upcoming year.

- **Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs ("LIS Rider")**
  If you qualify for a low-income subsidy and have been receiving Extra Help, this document will help you understand the amount of assistance you will be receiving for the 2022 plan year.

Express Scripts Medicare Customer Service Call here to find out in advance if a drug is covered or to ask other general questions.
Call: <1.XXX.XXX.XXXX>
TTY: 1.800.716.3231
Hours: 24 hours a day, 7 days a week

<Employer/Benefits Admin Name>
Write: <Employer/Benefits Administrator> <Address 1> <Address 2>
Call: <1.XXX.XXX.XXXX>
TTY: <1.XXX.XXX.XXXX>
Hours: <TBD> <TBD>

Quick Reference Guide

Grievance Contact Information Use this contact information to file a grievance.			
Write:	Express Scripts Medicare Attn: Grievance Resolution Team P.O. Box 3610 Dublin, OH 43016-0307	**Call:** **TTY:** **Fax:** **Hours:**	<1.XXX.XXX.XXXX> 1.800.716.3231 1.614.907.8547 24 hours a day, 7 days a week
Initial Coverage Reviews Use this contact information if you need an initial coverage decision for a medication that must be approved before the prescription can be filled at a participating retail or home delivery pharmacy, or to remove or change a restriction on a specific medication.			
Write:	Express Scripts Attn: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571	**Call:** **TTY:** **Fax:** **Hours:**	1.844.374.7377 (1.844.ESI.PDPS) 1.800.716.3231 1.877.251.5896 24 hours a day, 7 days a week
Appeals Contact Information Use this contact information if you need to file an appeal because your coverage review was denied or because your request to remove or change a restriction on a medication was denied.			
Write:	Express Scripts Attn: Medicare Appeals P.O. Box 66588 St. Louis, MO 63166-6588	**Call:** **TTY:** **Fax:** **Hours:**	1.844.374.7377 (1.844.ESI.PDPS) 1.800.716.3231 1.877.852.4070 24 hours a day, 7 days a week
Paper Claim Submission Mail requests to receive payment for medications already received with receipts to:			
Express Scripts Attn: Medicare Part D P.O. Box 14718 Lexington, KY 40512-4718 **To obtain a Direct Claim Form:** Download from our website, **express-scripts.com**, in the Medicare Resources Center found in the Benefits menu, or call Customer Service. The Direct Claim Form is not required, but it will help us process the information faster. It's a good idea to make a copy of all of your receipts for your records. You can fax us your request for payment 24 hours a day, 7 days a week to **1.608.741.5483.**			

<Logo> **<2022_XX_EM.eps>**

<Plan Option>

Express Scripts Medicare (PDP) for <Client Name>

Annual Notice of Changes for 2022

You are currently enrolled as a member of **Express Scripts Medicare**® (PDP). The benefit described in this document is your final benefit after combining the standard Medicare Part D benefit with additional coverage being provided by <Client Name>. Next year, there will be some changes to the plan's costs and benefits. *This booklet describes the changes.*

Changes to your Medicare coverage for next year can generally be made from October 15 through December 7. <The Annual Enrollment Period established by your former employer or your retiree group may differ from these dates. Please contact your group benefits administrator for more information.> [OR] <The Annual Enrollment Period established by <Client Name> is <Dates>. Please contact <Client Administrator> for more information.>

Additional Resources

- This document is available for free in other languages.
- For help or more information, contact Express Scripts Medicare Customer Service at **<1.XXX.XXX.XXXX>** (TTY users should call **1.800.716.3231**), 24 hours a day, 7 days a week. We have free language interpreter services available for non-English speakers.
- This information is also available in braille. Please call Express Scripts Medicare Customer Service at the numbers above if you need plan information in another format.

About Express Scripts Medicare

- Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. Enrollment in Express Scripts Medicare depends on contract renewal.
- When this booklet says "we," "us" or "our," it means *Medco Containment Life Insurance Company.* When it says "plan" or "our plan," it means Express Scripts Medicare.
- This information is not a complete description of benefits. Call Express Scripts Medicare at the phone numbers above for more information.
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).
- Other pharmacies are available in our network.

Think About Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year. Please see **Section 3** for more information about deadlines for changing plans. Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** It is important to review benefit and cost changes to make sure they will work for you next year. Please note this is only a summary of changes. Look in **Section 1** for information about benefit and cost changes for our plan.

- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in **Section 1** for information about changes to our drug coverage. Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?

- ☐ **Think about your overall costs in the plan.** How much will you spend out of pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?

If you decide to <u>stay</u> with Express Scripts Medicare:	**If you decide to <u>change</u> plans:**
If you want to stay with us next year, it's easy − you don't need to do anything. You will automatically stay enrolled in our plan.	If you decide other coverage will better meet your needs, look in **Section 2.2** to learn more about your choices. Please see **Section 3** for information about deadlines for changing plans. If you enroll in a new plan, your new coverage will begin on January 1, 2022.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

If any member pays a premium (customizable):

You will be informed of any changes to the amount that you pay for your premium<, if applicable,> prior to January 1, 2022. If you have any questions, please contact your group benefits administrator.

- Your monthly plan premium<, if applicable,> will be *more* if you are required to pay a lifetime Part D late enrollment penalty.
- If you have a higher income, you may have to pay an additional amount each month *directly to the government* for your Medicare prescription drug coverage.
- Your monthly premium<, if applicable,> will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see **Section 5** regarding "Extra Help" from Medicare.

If all members do not pay a premium (customizable):

Although you do not pay a premium, if you have a higher income, you may have to pay an additional amount each month *directly to the government* for your Medicare prescription drug coverage.

Section 1.2 – Changes to Part D Prescription Drug Coverage

Changes to Your Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" (also called the "Low Income Subsidy Rider" or "LIS Rider"), which tells you about your drug coverage and costs. If you get Extra Help and didn't receive this insert with this packet, please call Customer Service and ask for the LIS Rider. Phone numbers for Customer Service are on the front cover of this booklet.

This plan has <four> drug payment stages. Which "Drug Payment Stage" you are in may affect how much you pay for a Part D drug.
The following chart summarizes changes to the plan's drug payment stages and your cost-sharing amounts for covered prescription drugs. The changes shown will take effect on January 1, 2022, and will stay the same for the entire calendar year. How much you pay for a drug depends on which "tier" the drug is in. The costs in this chart are for prescriptions filled at network pharmacies. Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. There may be restrictions for prescriptions filled at out-of-network pharmacies, such as a limit on the amount of the drug you can receive.

	2021 (this year)	2022 (next year)
<MEMBER OUT-OF-POCKET MAXIMUM This plan has a yearly out-of-pocket maximum (costs paid by yourself only). Once you reach this amount, you will pay <$0> for your covered prescription drugs for the remainder of the calendar year, and the cost-share amounts listed in the various stages will not apply to you.>	$<insert 2021 MOOP if applicable>	$<insert 2022 MOOP if applicable>
YEARLY DEDUCTIBLE STAGE <<During this stage, **you pay the full cost** of <all of> your Part D <drugs><brand drugs><brand drugs at retail><drugs at network retail pharmacies>. You stay in this stage until you have paid your deductible amount. Once you meet your deductible, you move on to the Initial Coverage stage.>>	$<insert 2021 deductible> [If no deductible, see ANOC template instructions] This is how much you must pay for <all of> your Part D <drugs><brand drugs><brand drugs at retail> <drugs at network retail pharmacies> before the plan will pay its share.	$<insert 2022 deductible> [If no deductible, see ANOC template instructions] This is how much you must pay for <all of> your Part D <drugs><brand drugs><brand drugs at retail> <drugs at network retail pharmacies> before the plan will pay its share.

	2021 (this year)	2022 (next year)
INITIAL COVERAGE STAGE During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	The table below shows your costs for drugs in each of our <four> drug tiers. We moved some of the drugs on the drug list to different drug tiers. To see if any of your drugs have been moved to different tiers, look them up online at **express-scripts.com/documents** starting on October 15, 2021, or call Express Scripts Medicare Customer Service. For 2022, you will stay in this stage until the total cost of your Part D drugs reaches $4,430 (in 2021, the limit is $4,130). Once you reach this limit, you move on to the Coverage Gap stage. Most members will not reach the Coverage Gap stage. <<In 2021, you pay a <copayment/coinsurance> for drugs during the Initial Coverage stage. In 2022, you pay a <coinsurance/copayment> as noted in the chart below. To learn how copayments and coinsurance work, <look at **Chapter 4, Section 1.2,** *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage.*><contact Customer Service.>>	
<DAYS' SUPPLY>	*<If your client is moving to a narrow network, go to page 5 of the ANOC template instructions and include the network copy here.>* <The number of days in a one-month supply has changed from <XX> days in 2021 to <XX> days in 2022.>	
Drugs in Tier 1 *(Generic Drugs)* Cost for a one-month (<31>-day) supply of a drug in Tier 1 that is filled at a network retail pharmacy	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>
Cost for a three-month (90-day) supply of a drug in Tier 1 that is filled through our Express Scripts® Pharmacy home delivery service. Your cost share may differ at other home delivery pharmacies.	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>

	2021 (this year)	2022 (next year)
Drugs in Tier 2 *(Preferred Brand Drugs)* <31>-day supply filled at a network retail pharmacy	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>
90-day supply filled through our Express Scripts® Pharmacy home delivery service. Your cost share may differ at other home delivery pharmacies.	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>
Drugs in Tier 3 *(Non-Preferred <Brand> Drugs)* <31>-day supply filled at a network retail pharmacy	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>
90-day supply filled through our Express Scripts® Pharmacy home delivery service. Your cost share may differ at other home delivery pharmacies.	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>
Drugs in Tier 4 *(Specialty Tier Drugs)* <31>-day supply filled at a network retail pharmacy	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>
90-day supply filled through our Express Scripts® Pharmacy home delivery service. Your cost share may differ at other home delivery pharmacies.	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>	You pay <$[xx] per prescription.> [OR] <[xx]% of the total cost.>

	2021 (this year)	2022 (next year)
COVERAGE GAP STAGE *<If plan has a MOOP, use MOOP language from page 7 of ANOC Template Instructions.>*	*<Adjust Coverage Gap language if client has a different benefit design than described below. See examples starting on page 8 of ANOC Template Instructions.>* <<During this stage, the plan will <continue to><generally> cover your drugs at the same cost-sharing amount as in the Initial Coverage stage until you qualify for the Catastrophic Coverage stage. For 2022, you will stay in the Coverage Gap stage until you pay $7,050 **out of pocket** for Part D drugs (in 2021, you pay $6,550). Once you reach this yearly out-of-pocket amount, you move on to the Catastrophic Coverage stage.>>	
CATASTROPHIC COVERAGE STAGE This stage is the last of the drug payment stages. If you reach this stage, you will stay in this stage until the end of the calendar year.	You pay the greater of: $3.70 for a generic drug (including drugs treated as generics) and $9.20 for all other drugs OR 5% of the total cost<, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage>.	You pay the greater of: $3.95 for a generic drug (including drugs treated as generics) and $9.85 for all other drugs OR 5% of the total cost<, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage>.

Changes to Our Drug List

Our list of covered drugs is called a formulary or "drug list." Our drug list is available by logging into **express-scripts.com/documents**. This brings you to a PDF of our printed drug list for 2022, which will be available online beginning on October 15, 2021. We made some changes to our drug list, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. The drug list includes many – *but not all* – of the drugs that we will cover next year. If a drug is not on our list, it might still be covered. Contact Customer Service to determine whether your drug is covered.

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. To learn what you must do to ask for an exception, <see **Chapter 7** of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage*

decisions, appeals, complaints)) or call Customer Service.> [**OR**] <contact Customer Service at the numbers on the front cover of this document.>

- **Find a different drug** that we cover. You can call Customer Service at the numbers on the front cover of this document to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of certain drugs in the first 90 days of coverage of each plan year to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, <see **Chapter 3, Section 5.2** of the *Evidence of Coverage.*)> [**OR**] <contact Customer Service.)> During the time when you are getting a temporary supply of a drug, you should talk with your doctor 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.

If you currently have a formulary exception on file, you may need to submit a new request for an exception. The approval letter you received contains a start and end date for the approval. Please refer to this letter to determine if a request for a new exception is needed.

Most of the changes in the drug list are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the drug list during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online drug list as scheduled and provide other required information to reflect drug changes. <(To learn more about changes we may make to the Drug List, see **Chapter 3, Section 6** of the *Evidence of Coverage.*)>

Section 1.3 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. <Some network retail pharmacies, including <CVS><Walgreens> and select retail pharmacies in your plan, will provide up to a 90-day supply, while others will only dispense a one-month supply.> Please visit our website at **express-scripts.com** or call Express Scripts Medicare Customer Service for more information.

<<Beginning in 2022, you will><<You will continue to> have the choice of filling your retail prescriptions at pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within our network. Pharmacies that offer preferred cost-sharing are <Walgreens><CVS> as well as other national, regional and local retail pharmacies.>

<There are changes to our network of pharmacies for next year. However, the majority of pharmacies that participate in our network in 2021 will continue to participate in 2022. You can access information about what pharmacies are in our network by logging into **express-scripts.com/pharmacies** or by calling Customer Service. You can also ask us to mail you a *Pharmacy Directory.*> [**OR**] <Our network has changed more than usual for 2022. We

strongly recommend you review the most current information about our network of pharmacies to see if your pharmacy will remain in our network. You can access information about what pharmacies are in our network by logging into **express-scripts.com/pharmacies** or by calling Customer Service for updated pharmacy information. You can also ask us to mail you a *Pharmacy Directory*.>

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If You Want to Stay in Express Scripts Medicare

To stay in this plan, you don't need to do anything. You will automatically stay enrolled as a member of our plan for 2022.

Section 2.2 – If You Want to Change Plans

We hope to keep you as a member for next year, but if you are considering changing prescription drug plans, please contact your group benefits administrator for specific information about your group benefit. There may be additional implications to other benefits, such as loss of medical and/or dental coverage if you choose a plan outside your former employer's or your retiree group's offering. Your group benefits administrator will also be able to instruct you on how to terminate your current coverage.

Once you have discussed your options regarding coverage with your group benefits administrator, you may find more information about plans available in your area by contacting Medicare. You may visit https://www.medicare.gov/plan-compare or call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048, 24 hours a day, 7 days a week.

As a reminder, Express Scripts Medicare offers other Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums and cost-sharing amounts.

SECTION 3 Deadline for Changing Plans

If you want to change to a different prescription drug plan or to a Medicare health plan for next year, you can generally make changes from **October 15 through December 7.** The Annual Enrollment Period established by your former employer or your retiree group may differ from these dates. Please contact your group benefits administrator for more information. Your change in coverage will take effect on January 1, 2022.

Are there other times of the year to make a change?
In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid or those who get Extra Help paying for their drugs are allowed to make a change at other times of the year. <For more information, see **Chapter 8, Section 2** of the *Evidence of Coverage.>*

Note: If you're in a drug management program, you may not be able to change plans.

SECTION 4 Programs That Offer Free Counseling About Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. A SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can contact the SHIP in your state by <using the contact information provided in the **Appendix** of the enclosed *Evidence of Coverage* or by> contacting Medicare.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to seventy-five (75) percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not have a coverage gap or a late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, 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 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778 (applications); or
  - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** The State Pharmaceutical Assistance Program helps people pay for prescription drugs based on their financial need, age or medical condition. To learn more about the program, check with your State Pharmaceutical Assistance Program <(the name and phone numbers for your organization are in the **Appendix** of the enclosed *Evidence of Coverage*)>.

- **Prescription cost-sharing assistance for persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status. For information on eligibility criteria, covered drugs, or how to enroll in the program, check with your state AIDS Drug Assistance Program <(the name and phone numbers for your state's ADAP organization are in the **Appendix** of the enclosed *Evidence of Coverage*)>.

SECTION 6 Questions?

We're here to help. Please call Customer Service at <**1.XXX.XXX.XXXX>.** Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1.800.716.3231.**

Section 6.1 – Other Plan Information

If plan doesn't include EOC in ANOC package, use "Rights and rules" paragraph:

Rights and rules about next year's benefits
This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. The 2022 *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. You may request a copy of the *Evidence of Coverage* by calling Customer Service at the numbers on the front of this document. A copy of the *Evidence of Coverage* is located on our website at **express-scripts.com/documents**. You may also call Customer Service to ask us to mail you a copy.

If plan includes an EOC in ANOC package, use "Read your 2022 Evidence of Coverage" paragraph:

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits)
This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For additional plan details, look in the enclosed 2022 *Evidence of Coverage.* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **express-scripts.com/documents**. You can also review the enclosed *Evidence of Coverage* to see if other benefit changes affect you. You may also call Customer Service to ask us to mail you a copy.

Visit our website
You can visit our website at **express-scripts.com** for the most up-to-date information about our pharmacy network and drug coverage.

Notice of Privacy Practices
We have sent you a *Notice of Privacy Practices* upon your enrollment in this plan. Any changes made to this notice will be made available on our website. Should you require another copy of this notice, please contact Express Scripts Medicare Customer Service.

Section 6.2 – Getting Help From Medicare

- **To get information directly from Medicare:** Call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.
- **Visit the Medicare website:** You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage and quality ratings to help you compare Medicare prescription drug plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov/plan-compare.)
- **Read *Medicare & You* 2022:** You can read the *Medicare & You* 2022 handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the

Medicare website (https://www.medicare.gov) or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

<K00XXA2A>

EVIDENCE OF COVERAGE

EVERNORTH℠

Now that you've enrolled in a Medicare Part D plan, the Centers for Medicare & Medicaid Services (CMS) requires that Express Scripts Medicare send you certain plan materials. This *Evidence of Coverage* includes information on standard rules and processes for a Medicare Part D prescription drug plan program. However, there may be situations where the plan rules as outlined here differ from those of your former employer or retiree group.

Please be sure to review your other plan materials for plan-specific information or contact Express Scripts Medicare Customer Service.

January 1 – December 31, 2022

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of Express Scripts Medicare (PDP)

This document provides the details about your Medicare prescription drug coverage from January 1 – December 31, 2022. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, **Express Scripts Medicare**® (PDP), is offered by Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). (When this *Evidence of Coverage* says "we," "us" or "our," it means Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). When it says "plan" or "our plan," it means Express Scripts Medicare.)

Express Scripts Medicare Customer Service:

For more help or information, please call Express Scripts Medicare Customer Service at the number on the back of your member ID card (TTY users call: **1.800.716.3231**) or go to our plan website at **express-scripts.com**. Calls to Customer Service are free. Customer Service is available 24 hours a day, 7 days a week. Customer Service has free language interpreter services available for non-English speakers. This information is available in braille. Please contact Customer Service at the numbers above if you need plan information in another format.

This information is available for free in other languages. Please contact Customer Service at the numbers on the back of your member ID card for additional information. Customer Service is available 24 hours a day, 7 days a week. Esta información está disponible sin cargo en otros idiomas. Comuníquese con el Servicio de atención al cliente de Express Scripts Medicare llamando a los números que figuran al dorso de su tarjeta de identificación de miembro para obtener información adicional. El Servicio de atención al cliente está disponible las 24 horas, los 7 días de la semana.

Benefits, premium (if applicable), deductible (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary. Limitations, copayments and restrictions may apply.

2022 Evidence of Coverage

Table of Contents

Chapter 1. Getting started as a member of Express Scripts Medicare

SECTION 1 Introduction

Section 1.1 You are enrolled in Express Scripts Medicare, which is a Medicare prescription drug plan

Your former employer or your retiree group has chosen to provide your Medicare prescription drug coverage through our plan, Express Scripts Medicare.

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

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

This *Evidence of Coverage* tells you how to get your Medicare prescription drug coverage through our plan. It explains your rights and responsibilities and what is covered. The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of Express Scripts Medicare.

It's important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage*.

If you are confused or concerned or just have a question, please contact Express Scripts Medicare Customer Service (contact information is listed on the back of your member ID card).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Express Scripts Medicare covers your care. Other parts of this contract include your eligibility record, the 2022 *Formulary (List of Covered Drugs),* your *Benefit Overview,* your *Annual Notice of Changes* packet and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Express Scripts Medicare between January 1, 2022, and December 31, 2022.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Express Scripts Medicare after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services, or CMS) must approve Express Scripts Medicare each year. You can continue to get Medicare coverage as a member of our plan only as long as your former employer or your retiree group chooses to continue to offer the plan for the year in question and CMS renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You live in our geographic service area (**Section 2.3** below describes our service area).
- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B) (**Section 2.2** tells you about Medicare Part A and Medicare Part B).
- You are a United States citizen or are lawfully present in the United States.
- You qualify for coverage from your former employer or your retiree group.

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

Because you meet the requirements noted above in the previous section, you will receive prescription drug coverage (sometimes called Medicare Part D) through this plan. Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. This document and other plan materials you have received, such as the *Benefit Overview* or *Annual Notice of Changes,* describe that coverage.

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

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

Section 2.3 Here is the plan service area for Express Scripts Medicare

Although Medicare is a Federal program, Express Scripts Medicare is available only to individuals who qualify for coverage from their former employer or retiree group and live in our plan service area. To stay a member of our plan, you must continue to reside in the plan service area. Our service area includes all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

If you plan to move, please contact your group benefits administrator.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers for Social Security in **Chapter 2, Section 5.**

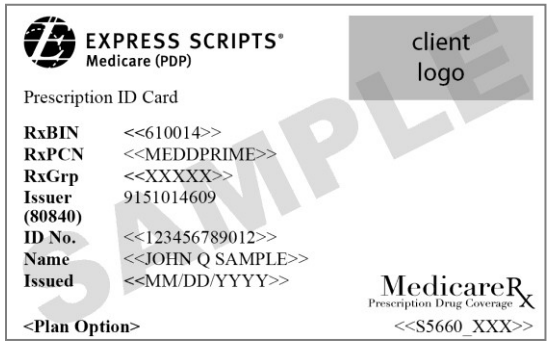
Section 2.4 U.S. Citizen or Lawful Presence

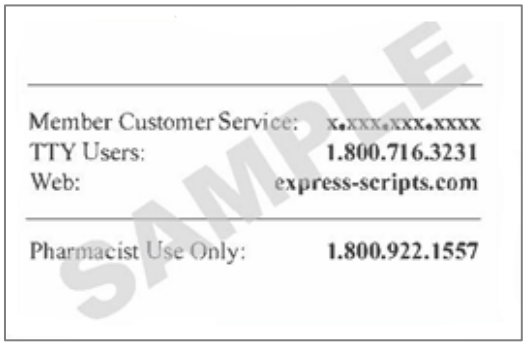
A member of a Medicare prescription drug plan must be a U.S. citizen or lawfully present in the United States. Medicare will notify Express Scripts Medicare if you are not eligible to remain a member on this basis. Express Scripts Medicare must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your member ID card: Use it to get all covered prescription drugs

While you are a member of our plan, you must use your member ID card for our plan for prescription drugs you get at network pharmacies. You should also show your provider your Medicaid card, if applicable. Below is a sample member ID card to show you what yours may look like. **If you are an existing member, your card may look slightly different.**





Please carry your card with you at all times and remember to show your card when you get covered drugs. If your member ID card is damaged, lost or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are listed on the back of your member ID card.)

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

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

How do you find participating network pharmacies?

Our *Pharmacy Directory* gives you a list of the network retail pharmacies closest to you — that means the pharmacies in your area that have agreed to fill covered prescriptions for our plan members — as well as other pharmacies (such as long-term care pharmacies) in our network.

Why do you need to know about network pharmacies?

With few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them. There may be changes to our network of pharmacies for 2022.

The *Pharmacy Directory* will tell you which pharmacies are in our network and, if available in your plan, which network pharmacies offer preferred cost-sharing. Preferred cost-sharing may be lower than the standard cost-sharing offered by other network pharmacies for some drugs. For certain plans, some network retail pharmacies may provide up to a 90-day supply, while others will only dispense a one-month supply. Not all drugs are available at a 90-day supply.

Our network may have changed more than usual for 2022. We strongly recommend you review the most current information about our network of pharmacies to see if your pharmacy will remain in our network by visiting us on the Web at **express-scripts.com/pharmacies** or by calling Customer Service for updated pharmacy information.

If you don't have a *Pharmacy Directory,* you can get a copy from Customer Service (phone numbers are listed on the back of your member ID card). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at **express-scripts.com/pharmacies**.

Section 3.3 The plan's 2022 *Formulary (List of Covered Drugs)*

The plan has a *Formulary (List of Covered Drugs)* for the 2022 plan year. We call it the "Drug List" for short. It tells you which commonly used Part D prescription drugs are covered by Express Scripts Medicare. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The Express Scripts Medicare Drug List meets the requirements set by Medicare and has been approved by Medicare.

The Drug List also tells you if there are any rules that restrict coverage for covered drugs, and it includes information for the covered drugs that are most commonly used by our members. However, we may cover additional Part D drugs that are not included in the printed Drug List. If one of your drugs is not listed in the printed Drug List, you should visit our website at **express-scripts.com/documents** to get the most complete and current information about which drugs are covered. Under "Prescriptions," click "Price a Medication." Or contact Express Scripts Medicare Customer Service (phone numbers are listed on the back of your member ID card) to find out if we cover it. You can also request that we mail you a copy of the Drug List.

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

When you use your Part D prescription drug benefits, Express Scripts Medicare prepares an *Explanation of Benefits* (Part D EOB), or summary, to help you understand and keep track of the costs of your prescription drugs and any payments made when you fill or refill a prescription. You may be able to receive a copy electronically by visiting our website, **express-scripts.com**, or by contacting Express Scripts Medicare Customer Service at the phone numbers on the back of this document.

The Part D EOB tells you the total amount you, others on your behalf, and we have spent on your Part D prescription drugs and the total amount paid for each of your Part D prescription drugs during each month the Part D Benefit is used. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower-cost options. **Chapter 4** gives more information about the Part D EOB and how it can help you keep track of your drug coverage.

The Part D EOB is also available upon request. To get a copy, please contact Customer Service at the phone numbers listed on the back of your member ID card. In addition to receiving your Part D EOB in the mail, you may also be able to receive a copy electronically by visiting our website, **express-scripts.com**.

SECTION 4 Your monthly premium for Express Scripts Medicare

Section 4.1 Your plan premium

Your coverage is provided through a contract with your former employer or your retiree group. Your group benefits administrator determines how your plan premium is paid. If you have questions about your plan premium, please contact your group benefits administrator for more information.

If your former employer or your retiree group charges you a plan premium or a portion of the plan premium, you are required to pay the premium according to their instructions.

If your former employer or your retiree group has not received your plan premium when it is due, a notice will be sent to you telling you that plan membership will end if they do not receive your plan premium within the grace period determined by your former employer or retiree group.

If your membership is ended due to nonpayment of premiums, you will not have prescription drug coverage until you enroll in another plan. However, you may still have Medicare Part A or Part B. At the time your membership is ended, premiums that have not been paid may still be owed to your former employer or your retiree group. If this occurs and you want to enroll again in our plan, contact your group benefits administrator. Any past-due premiums may need to be paid before you can be re-enrolled.

If you think your membership has been wrongfully ended, please contact your group benefits administrator to determine what steps you need to follow to have your coverage reinstated. **Chapter 7, Section 7** tells how to make a complaint. In addition, you must continue to pay any applicable Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be <u>less</u>
There are programs to help people with limited resources pay for their drugs. These include the Extra Help and State Pharmaceutical Assistance Programs. **Chapter 4** tells more about these programs. If you qualify, enrolling in one or both of these programs might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **some of the information in your other plan documents may not apply to you.** We will send you a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" (Low Income Subsidy (LIS) Rider), which tells you about your drug coverage. If you don't have this notice, please call Customer Service and ask for the LIS Rider. Phone numbers for Customer Service are listed on the back of your member ID card.

In some situations, your plan premium could be <u>more</u>
In some situations, your plan premium could be more than the amount charged by your former employer or retiree group. Some members are required to pay a **late enrollment penalty (LEP)** because they did not join a Medicare prescription 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 LEP is added to the plan's monthly premium.

- If you are required to pay the LEP, the cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. **Chapter 4, Section 9** explains the LEP.
- If you have an LEP and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums
In addition to paying your monthly Part D plan premium, some members may be required to pay other Medicare premiums, possibly for Medicare Part A or Part B. Most plan members may pay a premium for Medicare Part B.

Some members may be required to pay an extra charge, known as the Part D Income-Related Monthly Adjustment Amount, also known as Part D-IRMAA. If your modified adjusted gross income (MAGI) as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and this extra charge. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and you will lose your prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to **Chapter 4, Section 10.** You can also visit https://www.medicare.gov on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Or you may call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.

Your copy of the *Medicare & You* 2022 handbook gives information about the Medicare premiums in the section called "2022 Medicare Costs." This explains how the Part D premium differs for people with different incomes. Everyone with Medicare receives a copy of the *Medicare & You* 2022 handbook each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of the *Medicare & You* 2022 handbook from the Medicare website (https://www.medicare.gov). Or you can order a printed copy by phone at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Section 4.2 Can your former employer or your retiree group change your monthly plan premium during the year?

No. Your former employer or your retiree group is not allowed to change the amount it charges for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, you will be notified of the change in the fall and the change will take effect on January 1.

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for, or lose your eligibility for, the Extra Help program during the year. If a member qualifies for Extra Help with his or her prescription drug costs, the Extra Help program will pay all or part of the member's monthly plan premium. A member who loses his or her eligibility during the year will need to start paying his or her full monthly premium. You can find out more about the Extra Help program in **Chapter 4, Section 11.**

SECTION 5 Please keep your plan membership record up to date

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

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

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling either your group benefits administrator or Customer Service (phone numbers are listed on the back of your member ID card).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers for Social Security in **Chapter 2, Section 5.**

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct and complete, you don't need to do anything. If the information is incorrect or incomplete, or if you have other coverage that is not listed, please call the number noted in the letter you receive to provide us with the correct information to coordinate your benefits. If you have questions about who pays first, or you need to update your other insurance information, call Medicare's Benefits Coordination & Recovery Center (BCRC) toll free at 1.855.798.2627, Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users should call 1.855.797.2627.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to **Chapter 6, Section 1.3.**

SECTION 7 How other insurance works with our plan

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

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

These rules apply for employer or retiree group health plan coverage (other coverage outside of this plan):

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

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

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

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

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

Chapter 2. Important phone numbers and resources

SECTION 1 Express Scripts Medicare contacts
(how to contact us, including how to reach Express Scripts Medicare Customer Service at the plan)

How to contact Express Scripts Medicare Customer Service

For assistance with claims, billing or member ID card questions, please call or write to Express Scripts Medicare Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.
WRITE	Express Scripts Medicare P.O. Box 66535 St. Louis, MO 63166-6535
WEBSITE	**express-scripts.com**

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see **Chapter 7.**

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see **Chapter 7.** You may call us if you have questions about our coverage decision and appeals processes.

Method	Initial Coverage Reviews for Part D Prescription Drugs – Contact Information
CALL	**1.844.374.7377 (1.844.ESI.PDPS)** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.877.251.5896**
WRITE	Express Scripts Attn: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571
WEBSITE	**express-scripts.com**

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	**1.844.374.7377 (1.844.ESI.PDPS)** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.877.852.4070**
WRITE	Express Scripts Attn: Medicare Appeals P.O. Box 66588 St. Louis, MO 63166-6588
WEBSITE	**express-scripts.com**

How to contact us when you are making a complaint about the quality of care you have received, waiting times, customer service or other concerns

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the previous section about making an appeal.) For more information on making a complaint, see **Chapter 7.**

Method	Express Scripts Contact Information for Filing a Complaint
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.614.907.8547**
WRITE	Express Scripts Medicare Attn: Grievance Resolution Team P.O. Box 3610 Dublin, OH 43016-0307
MEDICARE WEBSITE	You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit an online complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See **Chapter 7** for more information.

Method	Express Scripts Contact Information for Payment Requests
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card.
FAX	**1.608.741.5483**
WRITE	Express Scripts ATTN: Medicare Part D P.O. Box 14718 Lexington, KY 40512-4718
WEBSITE	**express-scripts.com**

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

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities and people with End-Stage Renal Disease, also called ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare prescription drug plans, including our plan.

Method	Medicare – Contact Information
CALL	1.800.MEDICARE, or 1.800.633.4227 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1.877.486.2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	https://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Express Scripts Medicare: • **Tell Medicare about your complaint:** You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out and send it to you. (You can call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please refer to the SHIP listing located in the **Appendix** to find information about the SHIP in your state.

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

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

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

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. Please refer to the QIO listing located in the **Appendix** to find information about the QIO in your state.

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

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

SECTION 5 Social Security

The Social Security Administration (SSA) is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease (ESRD) 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. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security Administration – Contact Information
CALL	1.800.772.1213 Calls to this number are free. The SSA is available from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day, 7 days a week.
TTY	1.800.325.0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The SSA is available from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday.
WEBSITE	https://www.ssa.gov

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

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

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

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

To find out more about Medicaid and its programs, contact the Medicaid agency in your state (contact information is located in the **Appendix**).

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

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

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs (SPAPs). For more information, see **Chapter 4, Section 11.**

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice entitled "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" (Low Income Subsidy (LIS) Rider), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the LIS Rider. Phone numbers for Customer Service are listed on the back of your member ID card.

SECTION 1 Introduction

Section 1.1 This chapter explains rules for using this plan's coverage of Part D drugs

Your Part D prescription drugs are covered under our plan. In addition, Original Medicare (Medicare Part A and Part B) also covers some drugs:

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

To find out more about coverage through Original Medicare, see your *Medicare & You* 2022 handbook.

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

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See **Section 2** of this chapter for more information.)
- Your drug must be an approved Part D drug on the plan's 2022 formulary (we call it the Drug List for short). The printed Drug List includes information for the covered drugs that are most commonly used by our members, but the formulary may include drugs not listed in the printed Drug List. If one of your Part D drugs is not on the printed Drug List, you should visit us online at **express-scripts.com** or call Customer Service to find out if your drug is covered.
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. (See **Section 3** of this chapter for more information.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's home delivery service

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

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See **Section 2.5** for information about when we would cover prescriptions filled at out-of-network pharmacies.) A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

If your plan includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing, you may go to either type of network pharmacy to receive your covered prescription drugs. Your costs may be less at pharmacies with preferred cost-sharing. The *Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost-sharing.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, visit our website at **express-scripts.com/pharmacies** or call Customer Service (phone numbers are listed on the back of your member ID card). You can also look in your *Pharmacy Directory.* If you don't have a copy of the *Pharmacy Directory* and you would like one, please call Customer Service.

You may go to any of our network pharmacies. However, if your plan includes pharmacies that offer preferred cost-sharing, your costs may be less for your covered drugs at one of these pharmacies. If you switch from one network pharmacy to another and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

The *Pharmacy Directory* will tell you which, if any, network pharmacies offer preferred cost-sharing.

What if the pharmacy you have been using leaves the network?
If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Similarly, if your plan has pharmacies that offer preferred cost-sharing, and your pharmacy no longer offers preferred cost-sharing even though it's still in the plan's network, you may want to switch to a different pharmacy. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are listed on the back of your member ID card) or use the *Pharmacy Directory.* You can also find information on our website at **express-scripts.com/pharmacies**.

What if you need a specialty pharmacy?
Sometimes prescriptions must be filled at a specialty pharmacy. Specialty pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. LTC residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your LTC pharmacy is not in our network, please contact Customer Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.

- Pharmacies that dispense drugs that are restricted by the FDA to certain locations, or that require special handling, provider coordination or education on their use. (Note: This scenario should happen rarely.)

To locate a specialty pharmacy, visit our website at **express-scripts.com/pharmacies**, call Customer Service or check your *Pharmacy Directory*.

Section 2.3 Using the plan's home delivery service

When we refer to home delivery in this document, we are referring to prescriptions filled by the plan's home delivery service through Express Scripts® Pharmacy. For certain kinds of drugs, you can use the plan's home delivery service from Express Scripts® Pharmacy. Generally, the drugs provided through Express Scripts® Pharmacy are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's home delivery service are marked as **mail-order drugs** (MO) in our Drug List.

To get order forms and information about filling your prescriptions by mail, either visit our website at **express-scripts.com** and under "Prescriptions" click "Pharmacy Options" or call Customer Service at the numbers listed on the back of your member ID card.

Usually, a home delivery pharmacy order from Express Scripts® Pharmacy will get to you within 10 days. However, sometimes your home delivery may be delayed. Make sure you have at least a 14-day supply of medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a 30-day supply and fill it at a network retail pharmacy while you wait for your home delivery supply to arrive. If your home delivery shipment from Express Scripts® Pharmacy is delayed, please call Customer Service.

New prescriptions Express Scripts® Pharmacy receives directly from your doctor's office
The pharmacy will automatically fill and deliver new prescriptions it receives from healthcare providers, without checking with you first, if either:

- You used home delivery services with this plan in the previous twelve months, or
- You signed up for automatic delivery of all eligible new prescriptions received directly from healthcare providers. You may request automatic delivery of all new prescriptions now or at any time by contacting Customer Service. The request for automatic deliveries of new prescriptions only lasts until the end of the plan year (which is typically the last day of the calendar year), and you must submit a new request every year and/or each time you change plans.

Please note that not all prescriptions are eligible for automatic delivery. Medications commonly excluded from the program include those not indicated for chronic use (antibiotics, anti-infectives) or prescribed on an as-needed basis (pain medications), as well as medications with legal restrictions, supply limitations or controlled substances.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used home delivery in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Customer Service using the phone numbers on the back of your member ID card.

If you have never used our home delivery service and/or decide to stop automatic fills of new prescriptions, Express Scripts will contact you each time it gets a new prescription from a healthcare provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time

you are contacted to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your healthcare provider's office, please contact us by visiting our website at **express-scripts.com** or by calling Customer Service at the numbers listed on the back of your member ID card.

Refills on home delivery prescriptions from Express Scripts® Pharmacy. For refills of your drugs, you may have the option to sign up for an automatic refill program. Under this program, we will start to process your next refill automatically when our records show you should be close to running out of your drug. Express Scripts will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time. After we receive your prescription from your doctor, you will receive your medication within 7 days. (Over 85% of members receive their medications within 7 days. Longer delivery times may be due to additional correspondence needed with prescribers, medication availability and/or delivery times from the shipping vendor.)

To opt out of our program that automatically prepares home delivery refills, please contact us by visiting our website at **express-scripts.com** or by calling Customer Service. You should also provide the best ways to contact you by calling Customer Service at the numbers listed on the back of your member ID card. This way, the pharmacy can reach you to confirm your order before shipping.

Section 2.4 How can you get a maintenance supply of drugs?

When you get a maintenance supply of drugs, your cost-sharing amount may be lower. The plan offers three ways to get a long-term supply of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition.) You may order this supply through mail order or at some retail pharmacies.

1. **Some retail pharmacies** in our network may allow you to get a long-term supply of maintenance drugs. They may accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept this lower cost-sharing amount. In this case, you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at the numbers listed on the back of your member ID card for more information.
2. For certain kinds of drugs, you can use the plan's **home delivery service, Express Scripts® Pharmacy. The drugs available through our plan's home delivery service are marked as "MO" drugs in our Drug List.** See **Section 2.3** for more information about using our home delivery service. Our plan's mail-order service allows you to order a 90-day supply.
3. **Other home delivery pharmacies may have their own policies regarding prescriptions by mail.** We suggest that you contact those pharmacies directly for any requirements they may have.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

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

In a medical emergency. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

When traveling out of the plan's service area. If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the back of your member ID card to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

To obtain a covered drug in a timely manner. In some cases, you may be unable to obtain a covered drug in a timely manner within our service area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy.

If a network pharmacy does not stock a covered drug. Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible network retail pharmacy or through our home delivery pharmacy service. We will cover prescriptions at an out-of-network pharmacy under these circumstances.

In these situations, **please check first with Express Scripts Medicare Customer Service** to see if there is a network pharmacy nearby. Phone numbers for Customer Service are listed on the back of your member ID card. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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

SECTION 3 The plan's Drug List

Section 3.1 The Drug List tells you which commonly used Part D drugs are covered

The plan has a 2022 *Formulary (List of Covered Drugs).* In this *Evidence of Coverage,* **we call it the Drug List for short.** The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets the requirements set by Medicare and has been approved.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, **Section 1.1** explains about Part D drugs). For some plans, certain drugs may be covered for some medical conditions, but are not covered for other medical conditions. Drugs that are covered for only select medical conditions will be identified on our Drug List, along with the specific medical conditions that they cover.

We will generally cover a Part D drug as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either:*

- approved by the Food and Drug Administration (FDA). (That is, the FDA has approved the drug for the diagnosis or condition for which it is being prescribed.)
- – *or* – supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes both brand-name and generic drugs

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

Your specific plan may also cover certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. To understand your plan's specific coverage, review your *Benefit Overview* or call Customer Service.

What is *not* on the Drug List?

The plan does not cover all prescription drugs. In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see **Section 7.1** in this chapter). As mentioned previously, the Drug List does not contain all drugs covered by this plan. The Drug List contains the Part D drugs that are most commonly used by our members. If your drug is not included in the Drug List, you can call Customer Service to find out if we cover it.

Section 3.2 How can you find out if a specific Part D drug is covered by the plan?

You have three ways to find out:

1. Check the printed Drug List online at **express-scripts.com/documents**. Please note: The Drug List includes information for the covered drugs that are highly utilized by (or most commonly prescribed for) our members. However, we may cover additional Part D drugs that are not included in the printed Drug List.
2. Access information about which drugs are covered by your plan by logging into **express-scripts.com**, under "Prescriptions" click "Price a Medication." This information is always the most current.
3. Call Customer Service to find out if a particular drug is covered by the plan.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

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

Please note that sometimes a drug may appear more than once in our Drug List. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount or form of the drug prescribed by your healthcare provider (for instance, 10mg versus 100mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

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

Restricting brand-name drugs when a generic version is available
Generally, a generic drug works the same as a brand-name drug and usually costs less. In some Express Scripts Medicare plans, when a generic version of a brand-name drug is available, our network pharmacies will provide you with the generic version. Some Express Scripts Medicare plans will not cover the brand-name drug when a generic version is available. However, if this restriction applies to your plan, and your doctor has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.) To find out if this restriction applies to your plan, contact Customer Service.

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

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

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

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

To find out if any of these restrictions apply to a drug you take or want to take, check the plan's Drug List. For the most up-to-date plan-specific information, call Customer Service (phone numbers are listed on the back of your member ID card) or check our website at **express-scripts.com**.

If there is a restriction for a drug, it usually means that you or your doctor will have to take extra steps in order for us to cover the drug. You should contact Customer Service to learn what you or your doctor would need to do to get coverage for the drug. Phone numbers for Customer Service are listed on the back of your member ID card. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See **Chapter 7, Section 5.2** for information about asking for exceptions.)

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

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

We hope that your drug coverage will work well for you. But it's possible there could be a prescription drug you are currently taking, or one that you and your doctor think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- **In some Express Scripts Medicare plans, the drug might not be covered at all.** Or maybe a generic version of the drug is covered, but the brand-name version you want to take is not covered.
- **In other Express Scripts Medicare plans, the drug is covered, but there are extra rules or restrictions on coverage for that drug.** As explained in **Section 4,** some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. To find out what rules and restrictions apply to your Express Scripts Medicare plan, visit us online at **express-scripts.com/documents** beginning on October 15, 2021, to view a PDF of your plan's 2022 printed Drug List. You may also call Customer Service at the numbers on the back of your member ID card.
- **The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.** The plan puts covered drugs into different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

Section 5.2 What can you do if your drug is not covered or is restricted in some way?

If your drug is not covered or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your doctor time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

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

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

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

- The drug you have been taking is **no longer covered by the plan.**
- – *or* – the drug you have been taking is **now restricted in some way** (**Section 4** in this chapter tells about restrictions).

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

- **For those members who are new or who were in the plan last year:**
  We will cover a temporary supply of a drug that you took during the prior plan year **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year.** This temporary supply will be for at least a one-month supply, or less if your prescription is written for fewer days. In that case, you will be allowed multiple fills to provide up to a total of at least a one-month supply of the medication. The prescription must be filled at a network pharmacy.
- **For those who have been a member of the plan for more than 90 days and reside in an LTC facility and need a supply right away:** We will cover at least one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation. (Please note that the LTC pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

Other times when we will cover at least a temporary 30-day transition supply (or less if you have a prescription written for fewer days) include:

- When you enter an LTC facility
- When you leave an LTC facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

To ask for a temporary supply, call Customer Service (phone numbers are listed on the back of your member ID card).

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

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor find a covered drug that might work for you.

You can ask for an exception

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

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

In certain Express Scripts Medicare plans, you cannot ask us to change the cost-sharing tier for any drug in the specialty tier, if applicable.

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

Section 6.1 Your drug coverage can change during the year

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

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

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

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

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Customer Service for more information (phone numbers are listed on the back of your member ID card).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the cases below, you will be affected by the coverage changes during the current year.

- **A new generic drug replaces a brand-name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand-name drug or both)**
    - We may immediately remove a brand-name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand-name drug.
    - You or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see **Chapter 7** *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*
    - If you are taking the brand-name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand-name drug. You may not get this notice before we make the change.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
    - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
    - Your prescriber will also know about this change and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
    - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand-name drug or change the cost-sharing tier of or add new restrictions to the brand-name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give notice of the change and give a one-month refill of the drug you are taking at a network pharmacy.
    - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
    - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see **Chapter 7** *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in the plan.

- If we move your drug into a higher cost-sharing tier
- If we put a new restriction on your use of the drug
- If we remove your drug from the Drug List

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand-name drug or other changes noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year for any changes to drugs.

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

Section 7.1 Types of drugs we do not cover

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

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

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

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

Also, by law, the following categories of drugs are not covered by Medicare Part D plans. However, see your plan materials to find out if your former employer or your retiree group provides additional coverage of some of these drugs. Please call Customer Service for drug coverage specifics.

- Drugs when used for anorexia, weight loss or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs)
- Drugs when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR®, XELODA®)
- Non-prescription drugs, also known as over-the-counter (OTC) drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. Please refer to your formulary online or call Customer Service for more information. Phone numbers for Customer Service are listed on the back of your member ID card.

If you receive Extra Help paying for your drugs or have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in the **Appendix.**)

If your former employer or your retiree group does provide coverage of drugs not typically covered under a Medicare prescription drug plan, the amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage stage. (The Catastrophic Coverage stage is described in **Chapter 4, Section 7.**)

SECTION 8 Show your member ID card when you fill a prescription

Section 8.1 Show your member ID card

To fill your prescription, show your member ID card at the network pharmacy you choose. When you show your member ID card, the network pharmacy will automatically bill the plan for *our* share of your covered

prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

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

If you don't have your member ID card with you when you fill your prescription, ask the pharmacy to call Express Scripts to get the necessary information.

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

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

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

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service. Phone numbers for Customer Service are listed on the back of your member ID card.

What if you're a resident in an LTC facility and become a new member of the plan?
If you need a drug that is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for at least a 31-day supply, or less if your prescription is written for fewer days. (Please note that the LTC pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that isn't on our Drug List, or if the plan has restrictions on its coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days. To find out what rules and restrictions apply to your Express Scripts Medicare plan, visit us online at **express-scripts.com/documents** to view a PDF of your plan's formulary. You may also call Customer Service at the numbers on the back of your member ID card.

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

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

Your enrollment in Express Scripts Medicare doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

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

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage (other than through your former employer or retiree group)?

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

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

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

Section 9.5 What if you are in Medicare-certified Hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an antinausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive

notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. **Chapter 4** gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from certain pharmacies
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from certain prescribers
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination that you are at risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside the plan. See **Chapter 7** for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 A program to help members manage their medications

We have a Medication Therapy Management (MTM) program that can help our members with complex health needs.

This program is voluntary and free to members. A team of pharmacists and doctors developed it for us. The program can help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely may be able to get services through an MTM program. 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 and any problems or questions you have about your prescription and over-the-counter medications. 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. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other healthcare providers. Also, keep your medication list with you (for example, with your member ID card) in case you go to the hospital or emergency room.

If this program fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about this program, please contact Customer Service (phone numbers are listed on the back of your member ID card).

Chapter 4. Paying for your Part D prescription drugs

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

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs (SPAPs). For more information, see the **Appendix.**

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice entitled "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" (Low Income Subsidy (LIS) Rider), which tells you about your drug coverage. If you don't have this notice, please call Customer Service and ask for the LIS Rider. Phone numbers for Customer Service are listed on the back of your member ID card.

SECTION 1 Introduction

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

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

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions and what rules to follow when you get your covered drugs. Examples of some of the materials where you can find more information about your specific plan include the *Benefit Overview,* the *Quick Reference Guide* and any notices you receive from us about changes to your coverage or conditions that affect your coverage.

Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. **Chapter 3** also tells which types of prescription drugs are not covered by our plan.

In most situations, you must use a network pharmacy to get your covered drugs (see **Chapter 3** for the details). The *Pharmacy Directory* has a list of the closest retail pharmacies in the plan's network, as well as other pharmacies in the network. It also explains which pharmacies offer up to a three-month supply.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on the plan selected by your former employer or your retiree group and which drug payment stage you are in when you get the drug

Section 2.1 What are the standard Part D drug payment stages?

As shown in the table below, there are typically four drug payment stages for Medicare Part D plans. The plan selected by your former employer or retiree group will determine if your plan has a Deductible or Coverage Gap stage and how these stages will apply (see your other plan materials for more details). How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium (if applicable), regardless of the drug payment stage you are in.

NOTE: Check your *Benefit Overview* or *Annual Notice of Changes* to see if your former employer or your retiree group has an annual prescription drug out-of-pocket maximum. If so, you may pay a reduced cost or pay nothing once you reach that annual out-of-pocket maximum amount.

STAGE 1 *Yearly Deductible stage*	**STAGE 2** *Initial Coverage stage*	**STAGE 3** *Coverage Gap stage*	**STAGE 4** *Catastrophic Coverage stage*
If your plan has a deductible, you begin in this stage when you fill your first prescription of the plan year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid the deductible listed in your *Benefit Overview* or *Annual Notice of Changes.* (Details are in **Section 4** of this chapter.)	During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** Your share is shown in your *Benefit Overview* or *Annual Notice of Changes.* After you (or others on your behalf) have met your deductible (if your plan has a deductible), the plan pays its share of the cost of your drugs and you pay your share. You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $4,430. (Details are in **Section 5** of this chapter.)	Refer to your *Benefit Overview* or *Annual Notice of Changes* to determine if your plan has a Coverage Gap and what you and the plan will pay during this stage. You stay in this stage until your year-to-date **out-of-pocket costs** (your payments) reach a total of $7,050. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in **Section 6** of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year (through December 31, 2022). (Details are in **Section 7** of this chapter.)

SECTION 3 The Part D *Explanation of Benefits* (Part D EOB) explains payments for your drugs and which payment stage you are in

Section 3.1 We prepare a monthly summary for you called the Part D *Explanation of Benefits* (the Part D EOB)

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

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

Our plan will prepare a written summary called the Part D *Explanation of Benefits* (Part D EOB) when you have had one or more prescriptions filled through the plan during the previous month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower-cost options. The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows your total drug costs, including what the plan paid and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs for the year since the year began.
- **Drug price information.** This information will display the total drug price, and any percentage change from the first fill for each prescription claim of the same quantity.
- **Available lower-cost alternative prescriptions.** This will include information about other drugs with lower cost-sharing for each prescription claim that may be available.

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

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

- **Show your member ID card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your member ID card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions, go to **Chapter 5, Section 2.**) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchased a covered drug at a network pharmacy at a special price or used a discount card that was not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.

  - Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for the Catastrophic Coverage stage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we prepare for you.** The Part D EOB may be available electronically by visiting our website, **express-scripts.com**, or you can request a printed copy be mailed to you by calling Customer Service (phone numbers are listed on the back of your member ID card). Please look over the report to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 If the Deductible stage applies to your former employer or your retiree group plan, you pay the full cost of your drugs during this stage

Section 4.1 If your plan has a Deductible stage, you stay in this stage until you have paid the amount listed in your *Benefit Overview* or *Annual Notice of Changes*

If your plan does not have a deductible, please skip to Section 5.

The Deductible stage is the first payment stage for your drug coverage. It begins when you fill your first applicable prescription of the plan year. You will pay a yearly deductible in the amount listed in your *Benefit Overview* or *Annual Notice of Changes*. When you are in this stage, **you must pay the full cost of your drugs that apply to your deductible** until you reach the plan's deductible amount. Please refer to your *Benefit Overview* or *Annual Notice of Changes* to determine the amount of your deductible and to which drugs your deductible applies.

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

Once you have paid the applicable deductible, you leave the Deductible stage and move on to the next drug payment stage, which is the Initial Coverage stage.

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

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

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

Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A retail pharmacy in our plan's network that offers preferred cost-sharing, if your plan offers preferred and standard cost-sharing
- A pharmacy that is not in the plan's network
- The plan's home delivery pharmacy

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

Generally, we will cover your prescriptions only if they are filled at one of our network pharmacies. If your plan has pharmacies that offer preferred cost-sharing, you may go to either network pharmacies that offer preferred cost-sharing or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing. If your specific plan has network pharmacies that offer preferred cost-sharing, the *Pharmacy Directory* will also tell you which of the pharmacies in our network offer preferred cost-sharing.

Section 5.2 Your costs for covered Part D drugs

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

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

As shown in other plan documents you have received*,* the amount of the copayment or coinsurance also depends on which tier your drug is in.

- If your covered drug costs less than the copayment amount listed in your other plan materials*,* you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower.*
- We cover prescriptions filled at out-of-network pharmacies only in limited situations. Please see **Chapter 3, Section 2.5** for information about when we will cover a prescription filled at an out-of-network pharmacy.

Section 5.3 If your doctor provides less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, 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 (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- 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 copayment 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 copayment for your drug for a full month's supply (a 31-day supply) is $31. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so you can take fewer trips to the pharmacy. The amount you pay will depend on the days' supply you receive.

Section 5.4 You stay in the Initial Coverage stage until your total drug costs for the year reach $4,430

You stay in the Initial Coverage stage until the total amount for the prescription drugs you have filled and refilled reaches the **$4,430 limit for the Initial Coverage stage.**

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

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the plan year. (See **Section 6.2** for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The deductible you paid when you were in the Deductible stage (if applicable)
  - The total you paid as your share of the cost for your drugs during the Initial Coverage stage
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage stage. (If you were enrolled in a different Part D plan at any time during 2022, the amount that plan paid during the Initial Coverage stage also counts toward your total drug costs.)

The Part D EOB that we prepare for you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $4,430 limit in a year.

If you do reach this amount, we'll let you know. You will leave the Initial Coverage stage and move on to the Coverage Gap stage.

Please refer to your other plan materials for your plan-specific coverage in the Initial Coverage stage.

If your plan does not have a Coverage Gap stage, you will remain in the Initial Coverage stage until your total out-of-pocket costs reach $7,050. Once you reach this amount, you will move into the Catastrophic Coverage stage.

SECTION 6 Refer to your other plan materials to see what you pay and what the plan pays during the Coverage Gap stage

Section 6.1 You stay in the Coverage Gap stage until your out-of-pocket costs reach $7,050

When you are in the Coverage Gap stage, **you pay what is shown in your other plan materials** for this stage until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2022, that amount is $7,050.

Please refer to your other plan materials to determine if your plan has a Coverage Gap stage. If your plan does have a Coverage Gap stage, your other plan materials will indicate any additional coverage provided while in this stage.

Medicare Coverage Gap Discount Program
The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D members who either have reached the Coverage Gap stage or have a total drug spend of $4,430 and are not receiving Extra Help. For brand-name drugs, manufacturers provide a 70% discount on the negotiated price (excluding the dispensing fee, if any). The plan pays an additional 5% and you pay the remaining 25% for your brand-name drugs. You pay a portion (25%) of the dispensing fee.

If you reach the Coverage Gap, we will automatically apply the discount when your pharmacy bills you for your prescription, and your Part D EOB will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the Coverage Gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the Coverage Gap, the plan pays 75% of the price for generic drugs and you pay the remaining 25% of the price. The coverage for generic drugs works differently than the 70% discount for brand-name drugs. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the Coverage Gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are listed on the back of your member ID card).

The amounts above are the standard Medicare Part D cost-sharing amounts. See your other plan materials for the specifics of your coverage during the Coverage Gap stage. Your former employer or retiree group may provide continued coverage during the Coverage Gap stage for some or all of your drugs, or your plan may not have a Coverage Gap stage at all.

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

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

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

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

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

It matters who pays:

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

Moving on to the Catastrophic Coverage stage:

When you (or those paying on your behalf) have spent a total of $7,050 in out-of-pocket costs within the calendar year, you will move on to the Catastrophic Coverage stage.

These payments are **not included** in your out-of-pocket costs

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

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

Reminder: If any other organization, such as the ones listed above, pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are listed on the back of your member ID card).

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

- **We will help you.** The Part D *Explanation of Benefits* (Part D EOB) summary we prepare for you includes the current amount of your out-of-pocket costs (**Section 3** in this chapter tells about this report). When you reach a total of $7,050 in out-of-pocket costs for the year, this report will tell you that you have moved on to the Catastrophic Coverage stage.
- **Make sure we have the information we need. Section 3.2** in this chapter tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

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

You qualify for the Catastrophic Coverage stage when your out-of-pocket costs have reached the $7,050 limit for the calendar year. Once you are in the Catastrophic Coverage stage, you will stay in this payment stage until the end of the calendar year.

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

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - *–either –* coinsurance of 5% of the cost of the drug
    –or – a $3.95 copayment for covered generic drugs (including drugs treated as generics) and a $9.85 copayment for all other drugs.

  Our plan pays the rest of the cost.

The amounts above are the standard Medicare Part D cost-sharing amounts. Please refer to your *Benefit Overview* or *Annual Notice of Changes* to determine if your plan-specific coverage varies.

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

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

- The first part of coverage is the cost of **the vaccine medication itself.** The vaccine is a prescription medication.

- The second part of coverage is for the cost of **giving you the vaccine.** (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

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

1. **The type of vaccine** (what you are being vaccinated for)
   - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's 2022 *Formulary (List of Covered Drugs).*
   - 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 can also vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. 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 vaccine, 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 vaccine. Remember, you are responsible for all of the costs associated with vaccines (including their administration) during the

Deductible and Coverage Gap stages of your benefit (if these stages are applicable). Your actual costs may vary in each stage, depending on your plan design.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at a 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 or coinsurance for the vaccine and the cost of giving you the vaccine.
- Our plan will pay its share of the cost.

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in **Chapter 5.**
  - You will be reimbursed the amount you paid, less your normal coinsurance or copayment for the vaccine (including administration). Depending on how your specific plan is set up, this reimbursement may also be less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

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

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in **Chapter 5.**
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We're here to help. We recommend that you call us at Customer Service before getting vaccinated (phone numbers are listed on the back of your member ID card).

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

SECTION 9 Do you have to pay the Part D late enrollment penalty (LEP)?

Section 9.1 What is the Part D LEP?

Note: If you receive Extra Help from Medicare to pay for your prescription drugs, you will not pay an LEP.

The LEP is an amount that is added to your Part D premium. You may owe an LEP if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The cost of the late enrollment penalty depends on how long you went without Part D creditable prescription drug coverage.

The penalty may be added to your monthly premium. When you first enroll in Express Scripts Medicare, we let you know the amount of the penalty. If you are responsible for an LEP, it is considered to be part of your plan premium for as long as you have Part D coverage. If you do not pay your LEP, you could be disenrolled for failure to pay your plan premium.

Section 9.2 How much is the Part D LEP?

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

- First count the number of full months that you delayed enrolling in a Medicare prescription drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare prescription drug plans in the nation from the previous year. For 2022, this average premium amount is $33.37. This amount may change for 2023.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $33.37, which equals $4.67. This rounds to $4.70. This amount would be added **to the monthly premium amount for someone with an LEP.**

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

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

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, there are times when you may not have to pay the LEP.

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this **creditable coverage.**
  Please note:
  - Creditable coverage could include drug coverage from a former employer or retiree group, TRICARE or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You* 2022 handbook or call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving Extra Help from Medicare.

Section 9.4 What can you do if you disagree about your LEP?

If you disagree about your LEP, you or your representative can ask for a review of the decision about your LEP. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay an LEP. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that LEP. Call Customer Service at the numbers listed on the back of your member ID card to find out more about how to do this.

Important: Do not stop paying your LEP while you're waiting for a review of the decision about your LEP. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

Most people will pay their plan's standard monthly Part D premium. However, some people pay an extra amount because of their yearly income, which is called the Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA).

If your modified adjusted gross income as reported on your IRS return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income-Related Monthly Adjustment Amount, also known as Part D-IRMAA. Part D-IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security 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. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 10.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your Internal Revenue Service (IRS) tax return from 2 years ago is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1.800.772.1213. Automated services are available 24 hours a day, 7 days a week. You can speak with a representative between 7 a.m. and 7 p.m., Eastern Time, Monday through Friday. TTY users should call 1.800.325.0778.

Section 10.4 What happens if you do not pay the extra Part D amount?

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

SECTION 11 Information about programs to help people pay for their prescription drugs

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

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.

There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (the phone number is in the **Appendix**). Or call 1.800.MEDICARE (1.800.633.4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1.877.486.2048. You can also visit https://www.medicare.gov for more information.

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 7:00 a.m. and 7:00 p.m., Eastern Time, Monday through Friday. TTY users should call 1.800.325.0778 (applications); or
- Your State Medicaid Office (applications). (See the **Appendix** for contact information.)

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

We may be able to accept one of the following forms of Best Available Evidence (BAE) to establish that you qualify for Extra Help, when the evidence is provided by you or your pharmacist, advocate, representative, family member or other individual acting on your behalf:
1. A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during any month after June of the previous calendar year;
2. A copy of a state document that confirms active Medicaid status during any month after June of the previous calendar year;
3. A printout from the state electronic enrollment file showing Medicaid status during any month after June of the previous calendar year;
4. A screen print from the state's Medicaid systems showing Medicaid status during any month after June of the previous calendar year;
5. Other documentation provided by the state showing Medicaid status during any month after June of the previous calendar year;
6. A letter from the Social Security Administration (SSA) showing that the individual receives Supplemental Security Income (SSI); or
7. An Application Filed by Deemed Eligible confirming that the beneficiary is "…automatically eligible for extra help…" (SSA publication HI 03094.605).

The following proofs of institutional status are acceptable from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized, beginning on a date specified by the Secretary:
1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during any month after June of the previous calendar year;
2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
3. A screen print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar-month stay for Medicaid payment purposes during any month after June of the previous calendar year.

The following proofs of status are acceptable from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that an individual is receiving home and community-based services (HCBS) and qualifies for zero cost-sharing effective as of a date specified by the Secretary:
1. A State-issued Notice of Action, Notice of Determination or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;

2. A State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
3. A State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
4. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or
5. A State-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

You or your representative may fax or mail Best Available Evidence to the following fax number or address:

Fax: **1.855.297.7271**

Address: **Express Scripts Medicare (PDP)**
P.O. Box 4558
Scranton, PA 18505

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

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?
If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 70% discount on covered brand-name drugs. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?
The AIDS Drug Assistance Program (ADAP) helps ensure that 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 drug cost-sharing assistance in those states that have this program. 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/underinsured status.

If you are currently enrolled in an ADAP, it may continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information on eligibility criteria, covered drugs, or how to enroll in the program, please refer to the contact information located in the **Appendix.**

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?
No. If you get Extra Help, you already get coverage for your prescription drug costs during the Coverage Gap.

What if you don't get a discount and you think you should have?
If you think that you have reached the Coverage Gap and did not get a discount when you paid for your brand-name drug, you should review your next Part D *Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your Part D EOB, you should contact us to make sure that your prescription records are correct and up to date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in the **Appendix**) or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

State Pharmaceutical Assistance Programs (SPAPs)
Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules for providing drug coverage to its members. These programs provide limited-income and medically needy seniors and individuals with disabilities financial help for prescription drugs. Contact information for SPAPs is located in the **Appendix.**

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

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

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

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

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

1. **When you use an out-of-network pharmacy to get a prescription filled**
   If you go to an out-of-network pharmacy and try to use your member ID card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to **Chapter 3, Section 2.5** to learn more.)
   - Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
2. **When you pay the full cost for a prescription because you don't have your member ID card with you**
   If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.
   - Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
3. **When you pay the full cost for a prescription in other situations**
   You may pay the full cost of the prescription because you find that the drug is not covered for some reason.
   - For example, the drug may not be on the plan's Drug List, or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
   - If you are requesting payment for coverage of a Part D vaccine, such as a vaccine drug or administration of a vaccine drug, please save your invoice (bill) from your doctor and send a copy to us when you ask us to pay you back for our share of the cost.
   - In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.
4. **If you are retroactively enrolled in our plan**
   Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our plan and you paid out of pocket for any of your drugs after your enrollment

date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Customer Service are listed on the back of your member ID card.

5. **In a medical emergency**
   We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. **When traveling away from our plan's service area**
   If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the back of your member ID card to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled outside the United States, even for a medical emergency.

7. **To obtain a covered drug in a timely manner**
   In some cases, you may be unable to obtain a covered drug in a timely manner within our service area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

8. **If a network pharmacy does not stock a covered drug**
   Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible network retail pharmacy or through our home delivery pharmacy. We will cover prescriptions at an out-of-network pharmacy under these circumstances. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. **Chapter 7** has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

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

Send us your request for payment, along with a copy of your pharmacy prescription receipt or your pharmacy patient history printout signed by the dispensing pharmacist. A copy of an invoice (bill) is required for all other requests for payment, such as claims for vaccines from a physician or claims for Medicare Part D drugs from a hospital or clinic. It's a good idea to keep the original receipts or invoices, or to make copies, for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website, **express-scripts.com**, or call Customer Service and ask for a "Direct Claim Form." The phone numbers for Customer Service are listed on the back of your member ID card.

Mail your request for payment, together with any bills or paid receipts, to us at this address:

Express Scripts
Attn: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

You also have the option of faxing your claim form and receipts to **1.608.741.5483.**

You must submit your claim to us within 36 months of the date you received the service, item or drug.

Please be sure to contact Customer Service if you have any questions. Phone numbers for Customer Service are listed on the back of your member ID card. If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (**Chapter 3** explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 14 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to **Chapter 7.** The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading **Section 4** of **Chapter 7. Section 4** is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then, after you have read **Section 4,** you can go to **Section 5.5** in **Chapter 7** for a step-by-step explanation of how to file an appeal.

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

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

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

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

1. **When you buy the drug for a price that is lower than our price**
   Sometimes when you are in the Deductible stage and/or Coverage Gap stage (if they apply to your plan), you may be able to buy your drug **at a network pharmacy** for a price that is lower than our price.
   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
   - Unless special conditions apply, you must use a network pharmacy in these situations, and for some Express Scripts Medicare plans, your drug must be an approved Part D drug on the plan's 2022 formulary. The printed Drug List includes information for the covered drugs that are most commonly used by our members, but the formulary may include drugs not listed in the printed Drug List. If one of your Part D drugs is not on the printed Drug List, you should visit us online at **express-scripts.com/documents** or call Customer Service to find out if your drug is covered.
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage stage.
   - **Please note:** If you are in the Deductible stage and/or Coverage Gap stage (if they apply to your plan and the plan does not provide coverage in the gap), we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage stage more quickly.
2. **When you get a drug through a patient assistance program offered by a drug manufacturer**
   Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage stage.
   - **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage stage more quickly.

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

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member

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

We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. We can also give you information in braille or other alternate formats at no cost if you need it. To get information from us in a way that works for you, please call Express Scripts Medicare Customer Service at the numbers on the back of your member ID card.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with us at the numbers on the back of your member ID card. You may also file a complaint with Medicare by calling 1.800.MEDICARE (1.800.633.4227), or directly with the Office for Civil Rights. Contact information is included in this *Evidence of Coverage* or with this mailing, or you may contact us at the numbers located on the back of your member ID card for additional information.

Sección 1.1 Debemos proporcionar información de manera que funcione para usted (en idiomas que no sean inglés, en Braille o en formatos alternativos, etc.)

Debemos brindarle información acerca de los beneficios del plan en un formato que sea accesible y adecuado para usted. Nuestro plan tiene personas y servicios de interpretación gratuitos que están disponibles para responder las preguntas de miembros con discapacidades y que no hablan inglés. También podemos brindarle información en Braille u otros formatos alternativos sin costo, en caso de que lo necesite. Para obtener información de parte nuestra de manera que funcione para usted, llame al Servicio al cliente de Express Scripts Medicare a los números de teléfono que aparecen en el reverso de su tarjeta de identificación de miembro.

Si tiene alguna dificultad para recibir información de nuestro plan en un formato que sea accesible y adecuado para usted, llame para presentar una queja al número que aparece en el reverso de su tarjeta de identificación de miembro. También puede presentar un reclamo a Medicare llamando al 1.800.MEDICARE (1.800.633.4227), o comunicándose directamente con la Oficina de Derechos Civiles. Puede encontrar información de contacto en esta *Evidencia de Cobertura* o en esta correspondencia, o puede comunicarse con nosotros a los números de teléfono que aparecen en el reverso de su tarjeta de identificación de miembro para obtener información adicional.

Section 1.2 We must ensure that you get timely access to your covered drugs

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

Section 1.3 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held by the plan and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your doctor to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are listed on the back of your member ID card).

Section 1.4 We must give you information about the plan, its network of pharmacies and your covered drugs

As a member of Express Scripts Medicare, you have the right to get several kinds of information from us. (As explained in **Section 1.1,** you also have the right to get information from us in a way that works for you. This includes getting the information in languages other than English, in braille or in other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are listed on the back of your member ID card):

- **Information about our plan**
  This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members.

- **Information about our network pharmacies**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the retail pharmacies in your area and others that are in the plan's network, see the *Pharmacy Directory.*
  - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are listed on the back of your member ID card) or visit our website at **express-scripts.com/pharmacies**.
- **Information about your coverage and the rules you must follow when using your coverage**
  - To get the details on your Part D prescription drug coverage, see **Chapters 3** and **4,** plus the plan's 2022 *Formulary (List of Covered Drugs).* These chapters, together with the 2022 *Formulary (List of Covered Drugs),* tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are listed on the back of your member ID card).
- **Information about why something is not covered and what you can do about it**
  - 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 how a Part D drug is covered for you, you have the right to make an appeal and ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see **Chapter 7.** It gives you the details about how to make an appeal if you want us to change our decision. (**Chapter 7** also tells about how to make a complaint about quality of care, waiting times and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see **Chapter 5.**

Section 1.5 We must support your right to make decisions about your care

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

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

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

The legal documents that you can use to give your directions in advance in these situations are called **advance directives.** There are different types of advance directives and different names for them. Documents called a **living will** and a **power of attorney for healthcare** 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 the appropriate agency in your state, such as the Department of Health.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

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

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 (phone numbers are listed on the back of your member ID card).

Section 1.7 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights
If you 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 Services' **Office for Civil Rights** at 1.800.368.1019 for recorded information (TTY users, call 1.800.537.7697). You can also visit their website at https://www.hhs.gov/ocr/ or contact your regional 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** (phone numbers are listed on the back of your member ID card).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to **Chapter 2;** for information on how to contact it, go to the **Appendix.**
- Or **you can call Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Section 1.8 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** (phone numbers are listed on the back of your member ID card).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to **Chapter 2;** for information on how to contact it, go to the **Appendix.**
- You can contact **Medicare.**
    - You can visit the Medicare website to read or download the publication, "Your Medicare Rights and Protections." (The publication is available at: https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - Or you can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are listed on the back of your member ID card). We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this *Evidence of Coverage* and other plan documents you have received to learn what's covered and the rules you need to follow to get your covered drugs.
  - **Chapters 3** and **4** give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are listed on the back of your member ID card).
  - 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 coordinate your benefits. (For more information about coordination of benefits, go to **Chapter 1, Section 7.**)
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your member 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 healthcare 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 healthcare 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:
  - If you are responsible for a premium, you must pay it to continue being a member of this plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) *or* coinsurance (a percentage of the total cost). Your *Benefit Overview* or *Annual Notice of Changes* will tell you what you must pay for your Part D prescription drugs.
  - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see **Chapter 7** for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty (LEP), you must pay the penalty to remain a member of the plan.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call your group benefits administrator.
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (**Chapter 1** tells about our service area.)
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security. You can find the phone numbers and contact information for Social Security in **Chapter 2.**
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers for Customer Service are listed on the back of your member ID card.
  - For more information on how to reach us, including our mailing address, please see **Chapter 2.**

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

Background

SECTION 1 Introduction

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

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

- One for **coverage decisions and making appeals**
- And another process **for making complaints**

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

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

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. You will find phone numbers in the **Appendix.**

You can also get help and information from Medicare

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

- You can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.
- You can visit the Medicare website (https://www.medicare.gov).

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

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

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

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**	
Is your problem or concern about your benefits or coverage? (This includes problems about whether particular prescription drugs are covered or not, the way in which they are covered and problems related to payment for prescription drugs.)	
Yes. My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4: A guide to the basics of coverage decisions and appeals.**	**No.** My problem is not about benefits or coverage. Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

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

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

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

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

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

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this 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. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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 Review 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 additional levels of appeal.

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

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

- You **can call us at Customer Service** (phone numbers are listed on the back of your member ID card).

- You **can get free help** from your State Health Insurance Assistance Program (see **Section 2** of this chapter for more information).
- **For your Part D prescription drugs,** your doctor or other prescriber can request a coverage decision or a Level 1 or 2 Appeal on your behalf. You can also request an appeal higher than a Level 2 yourself. But if you want your doctor or other prescriber to request an appeal higher than a Level 2, they must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other prescriber or any other person to be your representative, call Customer Service (phone numbers for Customer Service are listed on the back of your member ID card) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The "Appointment of Representative" form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

Your benefits as a member of our plan include coverage for many prescription drugs. Please check the 2022 *Formulary (List of Covered Drugs)* online at **express-scripts.com/documents**. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain reference books. See **Chapter 3, Section 3** for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the 2022 *Formulary (List of Covered Drugs),* rules and restrictions on coverage, and cost information, see **Chapter 3** and **Chapter 4.**

Part D coverage decisions and appeals

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

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

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's 2022 *Formulary (List of Covered Drugs)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier

Please note that not all examples above apply to all Express Scripts Medicare plans. To find out what rules and restrictions apply to your Express Scripts Medicare plan, visit us online at **express-scripts.com/documents** to view a PDF of your plan's formulary. You may also call Customer Service at the numbers on the back of your member ID card.

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

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

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

Which of these situations are you in?

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

Section 5.2 What is an exception?

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

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Below are examples of exceptions that you or your doctor or other prescriber can ask us to make. (Please note that not all of these examples apply to all Express Scripts Medicare plans. To find out if this applies to your Express Scripts Medicare plan, visit us online at **express-scripts.com** and click on "Benefits," then "Medicare Resources" to view a PDF of your plan's formulary. You may also call Customer Service at the numbers on the back of your member ID card).

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

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

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that is set by the plan. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

- **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs we cover (for more information, go to **Chapter 3**).

Legal terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for an **exception.**

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

- **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in a specific cost-sharing tier. You can see what tier a drug is in by checking your plan's 2022 *Formulary (List of Covered Drugs)* online at **express-scripts.com**, under "Prescriptions" click "Price a Medication." In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

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

  - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
    - If the drug you're taking is a biological product, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological alternatives for treating your condition.
    - If the drug you're taking is a brand-name drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand-name alternatives for treating your condition.
    - If the drug you're taking is a generic drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
  - In certain Express Scripts Medicare plans, you cannot ask us to change the cost-sharing tier for any drug in the specialty tier, if applicable.

- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our plan's coverage includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval is typically valid for 12 months. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. **Section 5.5** tells you how to make an appeal if we say no.

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

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

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

What to do

- **Request the type of coverage decision you want.** Start by calling, writing or faxing us to make your request. You, your representative or your doctor (or other prescriber) can do this. You can also access information about the coverage decision process through our web site. For the details, go to **Chapter 2, Section 1** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.* Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request asking us to pay for our share of the cost of a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. **Section 4** of this chapter tells how you can give written permission to someone else to act as your authorized representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading **Chapter 5,** which describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the supporting statement.** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See **Sections 5.2** and **5.3** for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website at **express-scripts.com**.

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

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

- When we give you our coverage decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using *the standard deadlines could cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see **Section 7** of this chapter.)

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

Deadlines for a **fast** coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk 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. We will also tell you how to appeal the decision.

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 Review Organization. Later in this section, we talk 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. We will also tell you how you can appeal.

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 Review Organization. Later in this section, we talk 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. We will also tell you how to appeal the decision.

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

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

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

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

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

What to do

- **To start your appeal, you (or your authorized representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to **Chapter 2, Section 1** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone numbers shown in **Chapter 2, Section 1** *(How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.)*
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone numbers shown in Chapter 2, Section 1** *(How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.)*
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

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

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

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

- When we are 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 request.** 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 talk 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 you can 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 for a drug you have not received yet. 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 a "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 talk 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 request.
  - 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.
  - If you are requesting that we pay you back 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 give you a decision within 14 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 organization. Later in this section, we talk 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 30 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 and how you can appeal our decision.

Step 3 If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

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

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

If we say 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 we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal terms	The formal name for the Independent Review Organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

Step 1 To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

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

Step 2 The Independent Review Organization does a review of your appeal and gives you an answer.

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

Deadlines for **fast appeal** at Level 2

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

Deadlines for **standard appeal** at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 Appeal within 14 calendar days after it receives your request.

- **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.")

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

Step 3 If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 6** in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Appeal Levels 3, 4 and 5 for Part D drug requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal and both of your appeals have been turned down.

If the 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. The written response you receive to your Level 2 Appeal will explain whom 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 (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **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 or attorney adjudicator **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 or attorney adjudicator 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 or attorney adjudicator 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 (the Council)** will review your appeal and give you an answer. The Council is part of 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 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 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 whom 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 and make a decision.

- This is the last step of the appeals process.

Making complaints

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

? If your problem is about decisions related to benefits, coverage or payment, then this section is *not for you.* Instead, you need to use the process for coverage decisions and appeals. Go to **Section 4** of this chapter.

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

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of the following kinds of problems or concerns, you can make a complaint:

- If you are unhappy with the quality of care received
- If you feel someone did not respect your right to privacy or has shared information you feel should be confidential
- If you feel someone treated you disrespectfully
- If you received poor customer service
- If you feel you are being encouraged to leave the plan
- If you were kept waiting too long at the pharmacy or by Customer Service
- If you are unhappy with the condition or cleanliness of the pharmacy
- If you feel we have not given you a notice we are required to give or that written information was too difficult to understand

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals.

The process of asking for a coverage decision and making appeals is explained in **Sections 4–6** of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

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

- If you have asked us to give you a "fast response" for a coverage decision or appeal and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

Legal terms	• What this section calls a **complaint** is also called a **grievance.** • Another term for **making a complaint** is **filing a grievance.** • Another way to say **using the process for complaints** is **using the process for filing a grievance.**

Section 7.3 Step-by-step: Making a complaint

Step 1 Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Call us at the phone numbers listed on the back of your member ID card.
- **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.
  - If you call to make a complaint, an attempt will be made to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we will respond within 30 days.
  - If you prefer to make your complaint in writing, please send a letter with as much detail as possible to: Express Scripts Medicare, Attn: Grievance Resolution Team, P.O. Box 3610, Dublin, OH 43016-0307. All written complaints will be responded to within 30 days.
  - If you have a grievance regarding a denial for a request for a "fast coverage decision" or a "fast appeal," we will give you an answer within 24 hours.
- **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 response to a coverage decision or appeal, we will automatically give you a fast complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal terms	What this section calls a **fast complaint** is also called an **expedited grievance.**

Step 2 We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about *quality of care,* you also have two additional 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 healthcare experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address and phone number of the Quality Improvement Organization for your state, look in the **Appendix.** If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1.800.MEDICARE (1.800.633.4227). TTY users can call 1.877.486.2048.

Chapter 8. Ending your membership in this plan

Note: This chapter contains general information on disenrollment from a Medicare Part D plan and member options. For specific options available to you as a member of a group-sponsored plan or for more information, please contact your group benefits administrator.

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in this plan

Ending your membership in Express Scripts Medicare may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave this plan because you *or* your group benefits administrator has decided to end your membership. **You should always check with your group benefits administrator before leaving this plan.**
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in a Medicare Part D plan. **Section 2** tells you *when* you can end your membership in this plan. **As a member of a group-sponsored plan (such as this plan), you may end your membership in this plan at any time throughout the year if your group-sponsored plan allows changes, and you will be granted a Special Enrollment Period. Please contact your group benefits administrator for more information before making a decision to do so to ensure that you understand any additional implications of leaving this plan (for example, loss of medical or dental benefits).**
  - The process for voluntarily ending your membership varies, depending on what type of new coverage you are choosing. **Section 3** tells you *how* to end your membership.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. **Section 5** tells you about situations when we must end your membership.

If you are leaving this plan, you must continue to get your Part D prescription drugs through this plan until your membership ends.

SECTION 2 When can you end your membership in this plan?

You may end your membership in this plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave their plan during the Medicare Annual Enrollment Period. In certain situations, you may also be eligible to leave this plan at other times of the year.

Section 2.1 Usually, you can end your membership during the Medicare Annual Enrollment Period

You can end your membership during the **Medicare Annual Enrollment Period** (also known as the Annual Open Enrollment Period) or your former employer or your retiree group's annual enrollment period. This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Medicare Annual Enrollment Period?** This happens from October 15 to December 7 every year. **Your former employer or retiree group may have established an open enrollment period with different timing during which you may elect changes. Please contact your group benefits administrator for more information about any former employer or your retiree group-established open enrollment periods.**
    - **Since you are a member of a group-sponsored plan, you should contact your group benefits administrator for information regarding any other plan options available to you, as well as any implications of leaving this plan (such as loss of medical or dental benefits).**
- **Note:** If you're in a drug management program, you may not be able to change plans. **Chapter 3, Section 10** tells you more about drug management programs.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1. If you enroll in another plan during this period, your membership in this plan will end.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Express Scripts Medicare may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period.**

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples of special enrollment periods that are available. For the full list, you can contact the plan, call Medicare or visit the Medicare website (https://www.medicare.gov):
    - If you have moved out of your plan's service area
    - If you have Medicaid
    - If you are eligible for Extra Help with paying for your Medicare prescriptions
    - If we violate our contract with you
    - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
    - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). **Note:** PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service at the numbers located on the back of your member ID card.

  Note: If you're in a drug management program, you may not be able to change plans. **Chapter 3, Section 10** tells you more about drug management programs.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should 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.

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can call your former employer or retiree group benefits administrator.
- You can **call Customer Service** (phone numbers are listed on the back of your member ID card).
- You can find the information in the *Medicare & You* 2022 handbook.
    - Everyone with Medicare receives a copy of the *Medicare & You* 2022 handbook 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 (https://www.medicare.gov). Or you can order a printed copy by calling Medicare at the numbers below.
- You can contact **Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

SECTION 3 How do you end your membership in this plan?

For information about disenrolling from this plan, contact your group benefits administrator. Your group benefits administrator can best explain your options, the implications of leaving this plan and the process to follow to disenroll.

SECTION 4 Until your membership ends, you must keep getting your drugs through this plan

Section 4.1 Until your membership ends, you are still a member of this plan

If you leave Express Scripts Medicare, it may take time before your membership ends and your new Medicare coverage goes into effect. (See **Section 2** for information on when your new coverage begins.) During this time, you should continue to get your prescription drugs through this plan.

- **In order to have coverage through this plan until your new coverage starts, you should continue to use our network pharmacies to get your prescriptions filled until your membership in this plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our home delivery pharmacy service.

SECTION 5 Express Scripts Medicare must end your membership in certain situations

Section 5.1 When must we end your membership?

Express Scripts Medicare must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move out of our service area for more than 12 months.
    - If you move or take a long trip, you need to call Customer Service (phone numbers are listed on the back of your member ID card) to find out if the place you are moving or traveling to is in this plan's service area.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.

- 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 this plan and that information affects your eligibility for this plan. (We cannot make you leave this 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 this plan. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get prescription drugs. (We cannot make you leave this 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 do not pay any plan premiums you are responsible for according to your group's premium payment policy.
    - The plan must notify you in writing that you have a grace period to pay the plan premium before we end your membership. Contact your group benefits administrator for more information about your plan premium and its grace periods for paying your plan premium.
- 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 this plan and you will lose prescription drug coverage.

Where can you get more information?
If you have questions or would like more information on when we can end your membership, you can call Customer Service (phone numbers are listed on the back of your member ID card).

Section 5.2 We cannot ask you to leave this plan for any reason related to your health

Express Scripts Medicare is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?
If you feel that you are being asked to leave this plan because of a health-related reason, you should call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in this plan

If we end your membership in this plan, we must tell you our reasons in writing for ending your membership. We must also explain how to file a grievance or how to make a complaint about our decision to end your membership. You can also look in **Chapter 7, Section 7** for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 (TTY 1.800.537.7697) or your local Office for Civil Rights.

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

Chapter 10. Definitions of important words

2022 *Formulary (List of Covered Drugs)* or **Drug List** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs. The printed Drug List contains the most commonly used drugs and does not include all Part D drugs covered by this plan.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. **Chapter 7** explains appeals, including the process involved in making an appeal.

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

Catastrophic Coverage stage – The stage in the Part D drug benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,050 on covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. **Chapter 2** explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles (if they apply). Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." 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. See also "Grievance" in this list of definitions.

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium (if applicable).) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed copayment amount that a plan requires when a specific drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. 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 copayment.

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 medication isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document. **Chapter 7** explains how to ask us for a coverage decision.

Covered drugs – The term we use to mean all of the prescription drugs covered by this plan.

Creditable prescription drug coverage – Prescription drug coverage (for example, from an employer or retiree group) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Customer Service – A department within this plan responsible for answering your questions about your membership, benefits and filing grievances. See the back of your member ID card for information about how to contact Customer Service.

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 copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $31 and a one-month's supply in your plan is 31 days, then 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 you must pay for prescriptions before this plan begins to pay (if your plan has a deductible).

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

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

Drug Tier (Cost-sharing Tier) – Each drug on our drug list is placed in a drug, or cost-sharing, tier – for example, Generic Drugs tier. The amount you pay as a copayment or coinsurance depends, in part, on which tier the drug is in. You can find more information about tiers in your *Formulary (List of Covered Drugs).*

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 eligibility record 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 this plan.

Exception – A type of coverage decision allowing you to request that a plan restriction or limit be waived for certain drugs. Examples include: allowing a different dosage or quantity of a drug, allowing you to use a drug without getting approval for it in advance or allowing you to try a drug prescribed by your doctor that would normally require you to try a different drug first.

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

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

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

Initial coverage limit – The maximum limit of coverage under the Initial Coverage stage.

Initial Coverage stage – This is the stage before your total drug costs, including amounts you have paid and what your plan has paid on your behalf for the year, have reached $4,430.

Late enrollment penalty (LEP) – An amount that may be added to your monthly premium for Medicare prescription drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. 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 an LEP.

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 healthcare costs are covered if you qualify for both Medicare and Medicaid. See the **Appendix** for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. See **Chapter 3, Section 3** for more information about a medically accepted indication.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with End-Stage Renal Disease, also called ESRD (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. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan or a Medicare Medical Savings Account (MSA) Plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In many cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage (MA-PD).** Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Medicare Annual Enrollment Period is from October 15 until December 7 every year.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a health maintenance organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the Coverage Gap stage or total drug spend of $4,430 and who are not already receiving Extra Help. Discounts are based on agreements between the

Federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

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

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

"Medigap" (Medicare Supplement Insurance) policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Network pharmacy – A network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with this plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the Federal government and is not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital or other healthcare provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount and you pay your share. Original Medicare has two parts – Part A (Hospital Insurance) and Part B (Medical Insurance) – and is available everywhere in the United States.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with this plan to coordinate or provide covered drugs to members of this plan. As explained in this *Evidence of Coverage,* most drugs you get from out-of-network pharmacies are not covered by this plan unless certain conditions apply.

Out-of-pocket costs – See the definition for "cost-sharing" at the beginning of this chapter. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's out-of-pocket cost requirement. Your out-of-pocket costs are what move you toward the Catastrophic Coverage stage.

Part C – see Medicare Advantage (MA) Plan.

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

Part D drugs – Drugs that can be covered under Part D. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs. Please check your plan's 2022 *Formulary (List of Covered Drugs)* online at **express-scripts.com** or **Chapter 3** for more information on what drugs are covered by this plan.

Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income-Related Monthly Adjustment Amount, also known as

Part D-IRMAA. The Part D-IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Preferred cost-sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies, if your plan has pharmacies that offer preferred cost-sharing.

Premium – The periodic payment to Medicare, an insurance company or a healthcare plan for health or prescription drug coverage.

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

Quality Improvement Organization (QIO) – A group of practicing doctors and other healthcare experts paid by the Federal government to check and improve the care given to Medicare patients. See the **Appendix** for information about how to contact the QIO in your state.

Quantity limits – A type of plan restriction on certain drugs that is designed to limit the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may permanently disenroll you if you move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the plan's service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home or if we violate our contract with you.

Standard cost-sharing– Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy, if your plan has pharmacies that offer preferred cost-sharing.

Step Therapy – A type of plan restriction on certain drugs that requires you to first try another drug to treat your medical condition before we will cover the drug your doctor may have initially prescribed.

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

Appendix: Important phone numbers and resources

State Health Insurance Assistance Programs (SHIPs)
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.
The information in this Appendix is current as of 08/05/2021.

State:	Agency Address \ Website:	Telephone \ Hours:
Alabama	State Health Insurance Assistance Program (SHIP) Alabama Department of Senior Services RSA Tower 201 Monroe Street, Suite 350 Montgomery, AL 36104 http://www.alabamaageline.gov/	Toll-free: 1.800.243.5463 Toll-free: 1.877.425.2243 Local: 1.334.242.5743 Mon. – Fri. 8 a.m. – 5 p.m.
Alaska	State Health Insurance Assistance Program (SHIP) Alaska Medicare Information Office 550 W 7th Ave., Suite 1230 Anchorage, AK 99501 http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx	Toll-free: 1.800.478.6065 *(in-state only)* Local: 1.907.269.3680 TTY: 1.800.770.8973 Mon. – Fri. 8 a.m. – 5 p.m.
Arizona	State Health Insurance Assistance Program (SHIP) Arizona Department of Economic Security DES Division of Aging and Adult Services 1789 West Jefferson Street, MC 6288 Phoenix, AZ 85007 https://des.az.gov/services/older-adults/medicare-assistance	Toll-free: 1.800.432.4040 Local: 1.602.489.9635 Mon. – Fri. 7 a.m. – 3:30 p.m., except holidays
Arkansas	Senior Health Insurance Information Program Arkansas Insurance Department 1 Commerce Way Little Rock, AR 72202 https://insurance.arkansas.gov/pages/consumer-services/senior-health/	Toll-free: 1.800.224.6330 Local: 1.501.371.2782 Mon. – Fri. 8 a.m. – 4:30 p.m.
California	California Health Insurance Counseling and Advocacy Program (HICAP) California Department of Aging 1300 National Drive, Suite 200 Sacramento, CA 95834-1992 www.aging.ca.gov/Programs_and_Services/Medicare_Counseling	Toll-free: 1.800.434.0222

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State:	Agency Address \ Website:	Telephone \ Hours:
Colorado	Senior Health Insurance Assistance Program (SHIP) Colorado Division of Insurance 1560 Broadway, Suite 850 Denver, CO 80202 https://www.colorado.gov/pacific/dora/senior-healthcare-medicare	Toll-free: 1.888.696.7213 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Connecticut	CHOICES 55 Farmington Ave., 12th Floor Hartford, CT 06105-3730 https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/CHOICES-Connecticuts-program-for-Health-insurance-assistance-Outreach-Information-and-referral-Couns	Toll-free: 1.800.994.9422 *(in-state only)* Local: 1.860.424.5274 TTY: 1.860.247.0775 Mon. – Fri. 8:30 a.m. – 4:30 p.m.
Delaware	Delaware Medicare Assistance Bureau (DMAB) 1351 West North Street, Suite 101 Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	Toll-free: 1.800.336.9500 Local: 1.302.674.7364 Mon. – Fri. 8 a.m. – 4:30 p.m.
District of Columbia	State Health Insurance Assistance Program 250 E Street SW, 6th Floor Washington, DC 20024 https://dcoa.dc.gov/service/dc-state-health-insurance-assistance-program-ship	Local: 1.202.727.8370 Mon. – Fri. 9 a.m. – 1 p.m.
Florida	SHINE Program Florida Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000 http://www.floridashine.org/	Toll-free: 1.800.963.5337 TTY/TDD: 1.800.955.8770 Mon. – Fri. 8 a.m. – 5 p.m.
Georgia	GeorgiaCares Georgia DHS Division of Aging Services 2 Peachtree Street, NW, 33rd Floor Atlanta, GA 30303 http://www.mygeorgiacares.org/	Toll-free: 1.866.552.4464 *option #4* Local: 1.404.657.5258 Mon. – Fri. 8 a.m. – 5 p.m.

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State:	Agency Address \ Website:	Telephone \ Hours:
Guam	Division of Senior Citizens Guam 130 University Drive, Suite 8 University Castle Mall Mangilao, GU 96913 http://dphss.guam.gov/	Local: 1.671.735.7421 TTY: 1.671.735.7415
Hawaii	Hawaii SHIP Executive Office on Aging Department of Health No. 1 Capitol District 250 South Hotel Street, Suite 406 Honolulu, HI 96813-2831 https://www.hawaiiship.org	Toll-free: 1.888.875.9229 Local: 1.808.586.7299 TTY: 1.866.810.4379
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) Idaho Department of Insurance 700 West State Street, 3rd Floor P.O. Box 83720 Boise, ID 83720-0043 https://doi.idaho.gov/SHIBA/default	Toll-free: 1.800.247.4422 Mon. – Fri. 8 a.m. – 5 p.m., except holidays
Illinois	Senior Health Insurance Program (SHIP) Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271 https://www2.illinois.gov/aging/ship/Pages/default.aspx	Toll-free: 1.800.252.8966 TTY: 1.888.206.1327 Mon. – Fri. 8:30 a.m. – 5 p.m.
Indiana	State Health Insurance Assistance Program (SHIP) Indiana Department of Insurance 311 W. Washington Street, 2nd Floor Indianapolis, IN 46204-2787 www.medicare.in.gov	Toll-free: 1.800.452.4800 TDD: 1.866.846.0139 Mon. – Fri. 8 a.m. – 4:30 p.m.
Iowa	Senior Health Insurance Information Program (SHIIP) Iowa Insurance Division 1963 Bell Avenue, Suite 100 Des Moines, IA 50315 www.shiip.state.ia.us	Toll-free: 1.800.351.4664 TTY: 1.800.735.2942 *(in-state only)* Mon. – Fri. 8 a.m. – 4 p.m., except state holidays

State Health Insurance Assistance Programs (SHIPs)
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State:	Agency Address \ Website:	Telephone \ Hours:
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) Kansas Department for Aging and Disability Services New England Building 503 South Kansas Avenue Topeka, KS 66603-3404 http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick	Toll-free: 1.800.860.5260 Toll-free: 1.800.432.3535 *(in-state only)* TTY: 1.800.766.3777 Mon. – Fri. 8 a.m. – 5 p.m.
Kentucky	State Health Insurance Assistance Program (SHIP) Kentucky Cabinet for Health and Family Services Department for Aging and Independent Living 275 East Main Street 3E-E Frankfort, KY 40621 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	Toll-free: 1.877.293.7447 *option #2* Local: 1.502.564.6930 TTY: 1.888.642.1137 Mon. – Fri. 8 a.m. – 4:30 p.m.
Louisiana	Senior Health Insurance Information Program (SHIIP) Louisiana Department of Insurance P.O. Box 94214 Baton Rouge, LA 70802 http://www.ldi.la.gov/consumers/senior-health-shiip	Toll-free: 1.800.259.5300 or 1.800.259.5301 *(in-state only)* Local: 1.225.342.5301 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m.
Maine	State Health Insurance Assistance Program Office of Aging and Disability Services Maine Department of Health and Human Services 41 Anthony Avenue, SHS 11 Augusta, ME 04333 http://www.maine.gov/dhhs/oads/community-support/ship.html	Toll-free: 1.800.262.2232 Local: 1.207.287.9200 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Maryland	State Health Insurance Assistance Program (SHIP) Maryland Department of Aging 301 West Preston Street, Suite 1007 Baltimore, MD 21201 https://aging.maryland.gov/Pages/State-Health-Insurance-Program.aspx	Toll-free: 1.800.243.3425 *(in-state only)* Local: 1.410.767.1100 Out-of-state: 1.844.627.5465 TTY: 711 Mon. – Fri. 8:30 a.m. – 5 p.m.
Massachusetts	Serving the Health Information Needs of Everyone (SHINE) Executive Office of Elder Affairs One Ashburton Place, 5th Floor Boston, MA 02108 https://www.mass.gov/health-insurance-counseling	Toll-free: 1.800.243.4636 Local: 1.617.727.7750 TTY: 1.800.439.2370 Mon. – Fri. 9 a.m. – 5 p.m.

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.		
State:	**Agency Address \ Website:**	**Telephone \ Hours:**
Michigan	Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.) 6105 West St. Joseph Highway, Suite 204 Lansing, MI 48917 www.mmapinc.org	Toll-free: 1.800.803.7174 Local: 1.517.886.0899 Mon. – Fri. 8 a.m. – 5 p.m.
Minnesota	Senior LinkAge Line 540 Cedar Street St. Paul, MN 55164 http://mn.gov/senior-linkage-line/	Toll-free: 1.800.333.2433 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m.
Mississippi	State Health Insurance Assistance Program (SHIP) Mississippi Department of Human Services Division of Aging & Adult Services 200 South Lamar Street Jackson, MS 39201 http://www.mdhs.ms.gov/adults-seniors/	Toll-free: 1.844.822.4622 Local: 1.601.359.4500 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m.
Missouri	Missouri CLAIM 1105 Lakeview Avenue Columbia, MO 65201 www.missouriclaim.org	Toll-free: 1.800.390.3330 Local: 1.573.817.8300 Mon. – Fri. 9 a.m. – 4 p.m.
Montana	Montana State Health Insurance Assistance Program (SHIP) Senior and Long Term Care Division 1100 N Last Chance Gulch, 4th Floor Helena, MT 59601 https://dphhs.mt.gov/SLTC/aging/SHIP	Toll-free: 1.800.551.3191 TTY: 1.800.253.4091 or 1.800.253.4093 Mon. – Fri. 8 a.m. – 5 p.m.
Nebraska	Nebraska Senior Health Insurance Information Program (SHIIP) 2717 South 8th Street, Suite 4 Lincoln, NE 68502 www.doi.nebraska.gov/shiip	Toll-free: 1.800.234.7119 Mon. – Fri. 8 a.m. –5 p.m.
Nevada	State Health Insurance Assistance Program (SHIP) 3416 Goni Road, Suite D-132 Carson City, NV 89706 http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/	Toll-free: 1.800.307.4444 Local: 1.702.486.3478

State Health Insurance Assistance Programs (SHIPs)
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State:	Agency Address \ Website:	Telephone \ Hours:
New Hampshire	State Health Insurance Assistance Program 105 Pleasant Street Concord, NH 03301 www.nh.gov/servicelink	Toll-free: 1.866.634.9412 TTY: 711 Mon. – Fri. 8:30 a.m. – 4:30 p.m.
New Jersey	State Health Insurance Assistance Program (SHIP) New Jersey Department of Human Services Division of Aging Services P.O. Box 715 Trenton, NJ 08625-0715 www.state.nj.us/humanservices/doas/services/ship/	Toll-free: 1.800.792.8820 *(in-state only)* Mon. – Fri. 8:30 a.m. – 4:30 p.m.
New Mexico	Benefits Counseling Program New Mexico Aging and Long-Term Services Department P.O. Box 27118 Santa Fe, NM 87502-7118 http://www.nmaging.state.nm.us/senior-services.aspx	Toll-free: 1.800.432.2080 Local: 1.505.476.4799 TTY: 1.505.476.4937 Mon. – Fri. 7:45 a.m. – 5 p.m.
New York	Health Insurance Information, Counseling and Assistance Program (HIICAP) New York State Office for the Aging 2 Empire State Plaza Albany, NY 12223-1251 https://www.nyconnects.ny.gov/services/health-insurance-information-and-counseling-program-hiicap-1825	Toll-free: 1.800.342.9871 Mon. – Fri. 8:30 a.m. – 5 p.m.
North Carolina	Seniors' Health Insurance Information Program (SHIIP) North Carolina Department of Insurance 1201 Mail Service Center Raleigh, NC 27699-1201 www.ncdoi.com/SHIIP/Default.aspx	Toll-free: 1.855.408.1212 Local: 1.919.807.6900 TTY: 1.800.735.2962 Mon. – Fri. 8 a.m. – 5 p.m.
North Dakota	State Health Insurance Counseling Program (SHIC) North Dakota Insurance Department 600 East Boulevard Avenue Bismarck, ND 58505-0320 www.nd.gov/ndins/shic	Toll-free: 1.888.575.6611 Local: 1.701.328.2440 TTY: 1.800.366.6888 Mon. – Fri. 8 a.m. – 5 p.m., except state holidays

State Health Insurance Assistance Programs (SHIPs)
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.

State:	Agency Address \ Website:	Telephone \ Hours:
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP) Ohio Department of Insurance 50 West Town Street, 3rd Floor, Suite 300 Columbus, OH 43215 https://insurance.ohio.gov/wps/portal/gov/odi/about-us/divisions/oshiip#:~:text=The%20department%27s%20Ohio%20Senior%20Health%20Insurance%20Information%20Program,%28Part%20D%29%2C%20Medicare%20Advantage%20options%2C%20Medicare%20supplement%20insurance.	Toll-free: 1.800.686.1578 Local: 1.614.644.2673 TTY: 711 Mon. – Fri. 7:30 a.m. – 5 p.m.
Oklahoma	Senior Health Insurance Counseling Program (SHIP) Oklahoma Insurance Department 5 Corporate Plaza 3625 NW 56th Street, Suite 100 Oklahoma City, OK 73112 https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/	Toll-free: 1.800.763.2828 *(in-state only)* Local: 1.405.521.6628 Mon. – Fri. 8 a.m. – 5 p.m., except state holidays
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter Street NE Salem, OR 97309-0405 http://healthcare.oregon.gov/shiba/Pages/index.aspx	Toll-free: 1.800.722.4134 Local: 1.503.947.7979 Mon. – Fri. 8 a.m. – 5 p.m.
Pennsylvania	Pennsylvania Medicare Education and Decision Insight PA MEDI Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919 https://www.aging.pa.gov/	Toll-free: 1.800.783.7067 Local: 1.717.783.1550 Mon. – Fri. 8 a.m. – 4 p.m.
Puerto Rico	State Health Insurance Assistance Program (SHIP) P.O. Box 50063 San Juan, PR 00902	Toll-free: 1.877.725.4300 Local: 1.787.721.6121 TTY: 1.787.919.7291
Rhode Island	Health Insurance Assistance Program (SHIP) Office of Healthy Aging 25 Howard Avenue, Bldg. 57 Cranston, RI 02920 http://www.dea.ri.gov/	Toll-free: 1.888.884.8721 Local: 1.401.462.3000 TTY: 1.401.462.0740 Mon. – Fri. 8:30 a.m. – 4 p.m.
South Carolina	South Carolina Department on Aging 1301 Gervais Street, Suite 350 Columbia, SC 29201 https://aging.sc.gov/	Toll-free: 1.800.868.9095 Local: 1.803.734.9900 Mon. – Fri. 8:30 a.m. – 5 p.m.

State Health Insurance Assistance Programs (SHIPs)
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State:	Agency Address \ Website:	Telephone \ Hours:
South Dakota	Senior Health Information and Insurance Education (SHIINE) South Dakota Department of Social Services 700 Governors Drive Pierre, SD 57501 www.shiine.net	Toll-free: 1.800.536.8197 Local: 1.605.333.3314 Mon. – Fri. 8 a.m. – 4:30 p.m.
Tennessee	Tennessee State Health Insurance Information Program (SHIP) Tennessee Commission on Aging and Disability Andrew Jackson Building 502 Deaderick Street, 9th Floor Nashville, TN 37243-0860 https://www.tn.gov/aging.html	Toll-free: 1.877.801.0044 Local: 1.615.741.2056 TTY: 1.800.848.0299 Mon. – Fri. 8 a.m. – 5 p.m.
Texas	Health Information Counseling and Advocacy Program (HICAP) – Texas Health and Human Services Commission P.O. Box 149030 Austin, TX 78714-9030 https://hhs.texas.gov/services/health/medicare	Toll-free: 1.800.252.9240 TTY: 1.800.735.2989 Mon. – Fri. 8 a.m. – 5 p.m.
U.S. Virgin Islands	VI SHIP/Medicare 5049 Kongens Gade St. Thomas, VI 00802 VI SHIP/Medicare 1131 King Street, Suite 101 Christiansted, St. Croix, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	Local: 1.340.774.2991 *(St. Thomas/St. John)* Local: 1.340.773.6449 *(St. Croix)* Mon. – Fri. 8 a.m. – 5 p.m.
Utah	Senior Health Insurance Information Program (SHIIP) Aging and Adult Services of Utah 195 North 1950 West Salt Lake City, UT 84116 https://daas.utah.gov/seniors	Toll-free: 1.800.541.7735 Local: 1.801.538.3910 Mon. – Fri. 8 a.m. – 5 p.m.
Vermont	State Health Insurance Program (SHIP) 875 Roosevelt Hwy, Suite 210 Colchester, VT 05446 http://asd.vermont.gov/services/ship	Toll-free: 1.800.642.5119 *(in-state only)* Local: 1.802.865.0360 Mon. – Fri. 8:30 a.m.– 4:30 p.m.

State Health Insurance Assistance Programs (SHIPs)
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.

State:	Agency Address \ Website:	Telephone \ Hours:
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP) Virginia Division for the Aging 1610 Forest Avenue, Suite 100 Henrico, VA 23229 https://www.vda.virginia.gov/vicap.htm	Toll-free: 1.800.552.3402 Local: 1.804.662.9333 TTY: 711
Washington	Statewide Health Insurance Benefits Advisors (SHIBA) Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255 http://www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/	Toll-free: 1.800.562.6900 TTY: 1.360.586.0241 Mon. – Fri. 8 a.m. – 5 p.m., except holidays
West Virginia	West Virginia State Health Insurance Assistance Program (WV SHIP) West Virginia Bureau of Senior Services 1900 Kanawha Boulevard East Charleston, WV 25305 http://www.wvship.org/AboutWVSHIP/tabid/132/Default.aspx	Toll-free: 1.877.987.4463 Local: 1.304.558.3317 Mon. – Fri. 8 a.m. – 4 p.m.
Wisconsin	State Health Insurance Assistance Program (SHIP) Department of Health Services Board on Aging and Long Term Care 1 West Wilson Street Madison, WI 53703 https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm	Toll-free: 1.800.242.1060 Local: 1.608.266.1865 TTY: 1.888.701.1251 Mon. – Fri. 8 a.m. – 4:30 p.m.
Wyoming	Wyoming State Health Insurance Information Program (WSHIIP) 106 West Adams Avenue Riverton, WY 82501 http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	Toll-free: 1.800.856.4398 Local: 1.307.856.6880 Mon. – Fri. 8 a.m. – 5 p.m.

Quality Improvement Organizations
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.
The information in this Appendix is current as of 08/05/2021.

Region:	Agency Address \ Website:	Telephone \ Hours:
Region 1	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 https://www.keproqio.com/	Toll-free: 1.888.319.8452 Local: 1.216.447.9604 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 11 a.m. – 3 p.m. Local Time
Region 1 includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.		
Region 2	Livanta, LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 https://www.livantaqio.com	Toll-free: 1.866.815.5440 TTY: 1.866.868.2289 Fax: 1.855.236.2423 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Sat. – Sun. 11 a.m. – 3 p.m., Local Time 24 hour voicemail is available
Region 2 includes New Jersey, New York, Puerto Rico and U.S. Virgin Islands.		
Region 3	Livanta, LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 https://www.livantaqio.com	Toll-free: 1.888.396.4646 TTY: 1.888.985.2660 Fax: 1.855.236.2423 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Sat. – Sun. 11 a.m. – 3 p.m., Local Time 24 hour voicemail is available
Region 3 includes Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia.		
Region 4	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 https://www.keproqio.com/	Toll-free: 1.888.317.0751 Local: 1.813.280.8256 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 11 a.m. – 3 p.m. Local Time
Region 4 includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee.		

Quality Improvement Organizations TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.		
Region:	**Agency Address \ Website:**	**Telephone \ Hours:**
Region 5	Livanta, LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 https://www.livantaqio.com	Toll-free: 1.888.524.9900 TTY: 1.888.985.8775 Fax: 1.855.236.2423 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 11 a.m. – 3 p.m. Local Time 24 hour voicemail is available
Region 5 includes Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.		
Region 6	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 https://www.keproqio.com/	Toll-free: 1.888.315.0636 Local: 1.813.280.8256 TTY: 1.855.843.4776 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 11 a.m. – 3 p.m. Local Time
Region 6 includes Arkansas, Louisiana, New Mexico, Oklahoma and Texas.		
Region 7	Livanta, LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 https://www.livantaqio.com	Toll-free: 1.888.755.5580 TTY: 1.888.985.9295 Fax: 1.855.694.2929 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 11 a.m. – 3 p.m. Local Time 24 hour voicemail is available
Region 7 includes Iowa, Kansas, Missouri and Nebraska.		
Region 8	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 https://www.keproqio.com/	Toll-free: 1.888.317.0891 Local: 1.216.447.9604 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 11 a.m. – 3 p.m. Local Time
Region 8 includes Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming.		

Quality Improvement Organizations TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.		
Region:	**Agency Address \ Website:**	**Telephone \ Hours:**
Region 9	Livanta, LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105 https://www.livantaqio.com	Toll-free: 1.877.588.1123 TTY: 1.855.887.6668 Fax: 1.855.694.2929 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Sat. – Sun. 11 a.m. – 3 p.m., Local Time 24 hour voicemail is available
Region 9 includes Arizona, California, Hawaii, Nevada and Pacific Islands.		
Region 10	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 https://www.keproqio.com/	Toll-free: 1.888.305.6759 Local: 1.216.447.9604 TTY: 711 Fax: 1.844.878.7921 Mon. – Fri. 9 a.m. – 5 p.m., Local Time Weekends and Holidays from 11 a.m. – 3 p.m. Local Time
Region 10 includes Alaska, Idaho, Oregon and Washington.		

State Medicaid Offices
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The information in this Appendix is current as of 08/05/2021.

State:	Agency Address \ Website:	Telephone \ Hours:
Alabama	Alabama Medicaid Agency P.O. Box 5624 Montgomery, AL 36103-5624 http://www.medicaid.alabama.gov	Toll-free: 1.800.362.1504 Local: 1.334.242.5000 Mon. – Fri. 7 a.m. – 8 p.m. Sat. 9 a.m. – 5 p.m. Closed holidays
Alaska	Alaska Department of Health and Social Services 3901 Old Seward Highway, Suite 131 Anchorage, AK 99503 http://dhss.alaska.gov/	Toll-free: 1.800.478.7778 TTY: 1.907.586.4265 Mon. – Fri. 8 a.m. – 5 p.m.
American Samoa	American Samoa Medicaid State Agency P.O. Box 998383 Pago Pago, AS 96799 http://medicaid.as.gov	Local: 1.684.699.4777
Arizona	Arizona Health Care Cost Containment System (Arizona Medicaid Program) 801 East Jefferson Street Phoenix, AZ 85034 http://www.azahcccs.gov/	Toll-free: 1.855.432.7587 Local: 1.602.417.4000 TTY: 1.800.842.6520 Mon. – Fri. 8 a.m. – 5 p.m.
Arkansas	Division of Medical Services P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437 https://humanservices.arkansas.gov/divisions-shared-services/medical-services/contact-dms-2/	Toll-free: 1.800.482.8988 Local: 1.501.682.8233 Mon. – Fri. 8 a.m. – 4:30 p.m.
California	Medi-Cal Dept. of Health Care Services/Beneficiary Services Ctr. P.O. Box 138008 Sacramento, CA 95813-8008 http://www.dhcs.ca.gov	Local: 1.916.552.9200 Mon. – Fri. 8 a.m. – 5 p.m. Closed holidays
Colorado	Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 http://www.colorado.gov/hcpf	Toll-free: 1.800.221.3943 Local: 1.303.866.2993 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m. Closed on Fri. 2:30 p.m. – 3:30 p.m. Closed holidays

State Medicaid Offices
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State:	Agency Address \ Website:	Telephone \ Hours:
Connecticut	Husky Health Program c/o Department of Social Services 55 Farmington Avenue Hartford, CT 06105 http://www.ct.gov/hh/site/default.asp	Toll-free: 1.877.284.8759 TTY: 1.866.492.5276 Mon. – Fri. 8:30 a.m. – 6 p.m.
Delaware	Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 North DuPont Highway, Lewis Building New Castle, DE 19720 http://assist.dhss.delaware.gov/	Toll-free: 1.866.843.7212 Local: 1.302.571.4900 Mon. – Fri. 8 a.m. – 4:30 p.m.
District of Columbia	DC Department of Health Care Finance 441 4th Street, NW, 900S Washington, DC 20001 http://dhcf.dc.gov/	Local: 1.202.442.5988 TTY: 711 Mon. – Fri. 8:15 a.m. – 4:45 p.m.
Florida	Florida Agency for Health Care Administration P.O. Box 5197, MS 62 Tallahassee, FL 32314 http://www.flmedicaidmanagedcare.com/	Toll-free: 1.877.711.3662 TDD: 1.866.467.4970 Mon. – Thu. 8 a.m. – 8 .m. Fri. 8 a.m. – 7 p.m.
Georgia	Georgia Department of Community Health 2 Peachtree Street NW Atlanta, GA 30303 https://medicaid.georgia.gov	Local: 1.404.656.4507 Mon. – Fri. 8 a.m. – 5 p.m.
Guam	Department of Public Health and Social Services 123 Chalan Kareta Mangilao, GU 96913-6304 http://www.dphss.guam.gov/	Local: 1.671.735.7224 or 1.671.735.7302 Mon. – Fri. 8 a.m. – 5 p.m. Closed holidays

State Medicaid Offices
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State:	Agency Address \ Website:	Telephone \ Hours:
Hawaii	Med-QUEST P.O. Box 3490 Honolulu, HI 96811 www.medquest.hawaii.gov	Local: 1.808.524.3370 TTY/TDD: 1.808.692.7182 *(Oahu)* Toll-free: 1.800.316.8005 TTY/TDD: 1.800.603.1201 *(Neighbor Islands)* Mon. – Fri. 7:45 a.m. – 4:30 p.m. Closed holidays
Idaho	Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720-0036 http://www.healthandwelfare.idaho.gov	Local: 1.877.456.1233 TTY/TDD: 1.888.791.3004 Mon. – Fri. 8 a.m. – 5 p.m.
Illinois	Illinois Department of Human Services Administrative Offices 100 South Grand Avenue East Springfield, IL 62704 https://www.dhs.state.il.us/page.aspx	Toll-free: 1.800.843.6154 TTY: 1.866.324.5553 Mon. – Fri. 8 a.m. –5 p.m.
Indiana	Family and Social Services Administration Office of Medicaid Policy and Planning 402 West Washington Street P.O. Box 7083 Indianapolis, IN 46204 http://www.in.gov/medicaid/members/	Toll-free: 1.800.403.0864 Mon. – Fri. 8 a.m. – 4:30 p.m.
Iowa	Iowa Medicaid Enterprise Department of Human Services – Member Services P.O. Box 36510 Des Moines, IA 50315 http://dhs.iowa.gov/iahealthlink	Toll-free: 1.800.338.8366 Local: 1.515.256.4606 TTY: 1.800.735.2942 Mon. – Fri. 8 a.m. – 5 p.m.
Kansas	Kansas Medical Assistance Program P.O. Box 3571 Topeka, KS 66601 http://www.kancare.ks.gov/	Toll-free: 1.866.305.5147 TTY: 1.800.766.3777 Mon. – Fri. 7:30 a.m. – 5:30 p.m.

State Medicaid Offices
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State:	Agency Address \ Website:	Telephone \ Hours:
Kentucky	Department for Medicaid Services 275 East Main Street 6W-A Frankfort, KY 40601 http://chfs.ky.gov/agencies/dms/Pages/default.aspx	Toll-free: 1.800.635.2570 Local: 1.502.564.4321 Mon. – Fri. 8 a.m. – 7 p.m.
Louisiana	Department of Health P.O. Box 629 Baton Rouge, LA 70821-0629 http://www.dhh.louisiana.gov	Toll-free: 1.888.342.6207 Local: 1.225.342.9500 Mon. – Fri. 8 a.m. – 4:30 p.m.
Maine	Office for Family Independence 114 Corn Shop Lane Farmington, ME 04938 http://mainecare.maine.gov	Toll-free: 1.800.977.6740 Toll-free: 1.855.797.4357 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Maryland	Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201-2399 http://mmcp.dhmh.maryland.gov/	Toll-free: 1.877.463.3464 Local: 1.410.767.6500 Mon. – Fri. 8:30 a.m. – 5 p.m.
Massachusetts	MassHealth Office of Medicaid 100 Hancock St., 6th Floor Quincy, MA 02171 http://www.mass.gov/masshealth	Toll-free: 1.800.841.2900 TTY: 1.800.497.4648 Mon. – Fri. 8 a.m. – 5 p.m.
Michigan	Michigan Department of Health and Human Services Medicaid Program 333 S. Grand Avenue P.O. Box 30195 Lansing, MI 48909 www.michigan.gov/medicaid	Toll-free: 1.800.642.3195 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Minnesota	Department of Human Services Health Care Eligibility and Access Division P.O. Box 64989 St. Paul, MN 55164-0989 http://mn.gov/dhs	Toll-free: 1.800.657.3739 Local: 1.651.431.2670 TTY: 1.800.627.3529 Mon. – Fri. 8 a.m. – 5 p.m.

State Medicaid Offices
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State:	Agency Address \ Website:	Telephone \ Hours:
Mississippi	Mississippi Division of Medicaid Sillers Building 550 High Street, Suite 1000 Jackson, MS 39201 http://www.medicaid.ms.gov	Toll-free: 1.800.421.2408 Local: 1.601.359.6050 TTY: 1.228.206.6062 Mon. – Fri. 7:30 a.m. – 5 p.m.
Missouri	The State of Missouri MO HealthNet Division 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500 http://dss.mo.gov/mhd	Toll-free: 1.800.392.2161 Local: 1.573.751.3425 TTY: 1.800.735.2966 Mon. – Fri. 8 a.m. – 5 p.m.
Montana	Department of Public Health and Human Services Health Resources Division Cogswell Building, 1400 East Broadway Helena, MT 59601-5231 http://www.dphhs.mt.gov/	Toll-free: 1.888.706.1535 TTY: 1.800.833.8503 Mon. – Fri. 7 a.m. – 6 p.m.
Nebraska	Nebraska Department of Health and Human Services P.O. Box 95026 Lincoln, NE 68509-5026 http://dhhs.ne.gov/	Toll-free: 1.855.632.7633 Local: 1.402.473.7000 *(Lincoln)* Local: 1.402.595.1178 *(Omaha)* TTY: 1.402.471.7256 Mon. – Fri. 8 a.m. – 5 p.m.
Nevada	Department of Health and Human Services Division of Health Care Financing and Policy 1100 East William Street, Suite 102 Carson City, NV 89701 http://dhcfp.nv.gov/	Toll-free: 1.877.638.3472 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
New Hampshire	Department of Health and Human Services Office of Medicaid Business and Policy 129 Pleasant Street Concord, NH 03301 http://www.dhhs.nh.gov/index.htm	Toll-free: 1.800.852.3345 *extension 4344* *(in-state only)* Local: 1.603.271.4344 TDD: 1.800.735.2964 Mon. – Fri. 8 a.m. – 4:30 p.m.

State Medicaid Offices
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State:	Agency Address \ Website:	Telephone \ Hours:
New Jersey	New Jersey Department of Human Services Division of Medical Assistance and Health Services P.O. Box 712 Trenton, NJ 08625-0712 http://www.state.nj.us/humanservices/dmahs	Toll-free: 1.800.356.1561 *(in-state only)* TTY: 711 Mon. – Fri. 8:30 a.m. – 4:45 p.m.
New Mexico	NM Human Services Department Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504-2348 https://www.hsd.state.nm.us/	Toll-free: 1.800.283.4465 TTY: 1.855.227.5485 Mon. – Fri. 8 a.m. – 4:30 p.m.
New York	New York State Department of Health Corning Tower Empire State Plaza Albany, NY 12237 http://www.health.ny.gov/	Toll-free: 1.800.541.2831 TTY: 1.800.662.1220 Mon. – Fri. 8 a.m. – 8 p.m. Sat. 9 a.m. – 1 p.m. Closed holidays
North Carolina	North Carolina Medicaid Division of Health Benefits 2501 Mail Service Center Raleigh, NC 27699-2501 http://www.ncdhhs.gov/dma	Toll-free: 1.888.245.0179 Local: 1.919.855.4100 Mon. – Fri. 8 a.m. – 5 p.m. Closed holidays
North Dakota	Medical Services Division North Dakota Department of Human Services 600 East Boulevard Avenue, Department 325 Bismarck, ND 58505-0250 http://www.nd.gov/dhs	Toll-free: 1.800.755.2604 Local: 1.701.328.7068 TTY: 1.800.366.6888 Mon. – Fri. 8 a.m. – 5 p.m.
Northern Mariana Islands	CNMI State Medicaid Agency Government Bldg. No. 1252 Capitol Hill Rd. Caller Box 10007 Saipan, MP 96950 http://medicaid.cnmi.mp/	Local: 1.670.664.4890 Mon. – Thu. 7:30 a.m. – 1 p.m. Closed Friday and holidays
Ohio	Department of Medicaid 50 West Town Street, Suite 400 Columbus, OH 43215 http://medicaid.ohio.gov/	Toll-free: 1.800.324.8680 Mon. – Fri. 7 a.m. – 8 p.m. Sat. 8 a.m. – 5 p.m.

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State:	**Agency Address \ Website:**	**Telephone \ Hours:**
Oklahoma	Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105 http://okhca.org/	Toll-free: 1.800.987.7767 Local: 1.405.522.7300 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Oregon	Oregon Health Plan Health Systems Division 500 Summer Street, NE, E-20 Salem, OR 97301-1097 http://www.oregon.gov/oha/Pages/Contact-Us.aspx	Toll-free: 1.800.527.5772 Local: 1.503.945.5772 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Pennsylvania	Department of Human Services Office of Medical Assistance Programs P.O. Box 2675 Harrisburg, PA 17105-2675 http://www.dhs.pa.gov/	Toll-free: 1.800.842.2020 TTY: 711 Mon. – Fri. 8:30 a.m. – 4:30 p.m.
Puerto Rico	Programa Medicaid Departamento de Salud P.O. Box 70184 San Juan, PR 00936-8184 http://medicaid.pr.gov	Local: 1.787.641.4224 TTY:1.787.625.6955 Mon. – Fri. 8 a.m. – 6 p.m.
Rhode Island	Rhode Island Executive Office of Health and Human Services 3 West Road Cranston, RI 02920 http://www.dhs.ri.gov	Local: 1.401.784.8100 TTY: 1.800.745.5555 Mon. – Fri. 8 a.m. – 5 p.m.
South Carolina	Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206 http://www.scdhhs.gov	Toll-free: 1.888.549.0820 TTY: 1.888.842.3620 Mon. – Fri. 8 a.m. – 6 p.m.

State Medicaid Offices
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.

State:	Agency Address \ Website:	Telephone \ Hours:
South Dakota	Department of Social Services Attn: Medicaid 700 Governors Drive Pierre, SD 57501 http://dss.sd.gov	Local: 1.605.773.4678 Local: 1.605.668.3100 Mon. – Fri. 8 a.m. – 5 p.m.
Tennessee	TennCare 310 Great Circle Road Nashville, TN 37243 http://www.tn.gov/tenncare/	Toll-free: 1.855.259.0701 Toll-free: 1.800.342.3145 TTY: 1.800.848.0298 Mon. – Fri. 8 a.m. – 5 p.m.
Texas	Texas Health and Human Services Commission P.O. Box 149024 Austin, TX 78714-9024 http://yourtexasbenefits.com	Toll-free: 1.800.335.8957 Toll-free: 1.800.252.8263 TTY: 711 Mon. – Fri. 7 a.m. – 7 p.m.
U.S. Virgin Islands	VI Medicaid Program Department of Human Services Knud Hansen Complex 1303 Hospital Ground, Bldg. A St. Thomas, VI 00802 VI Medicaid Program Department of Human Services 3011 Golden Rock, Christiansted St. Croix, VI 00820 http://www.vimmis.com/default.aspx	Local: 1.340.715.6929 Mon. – Fri. 7 a.m. – 7 p.m.
Utah	Utah Department of Health Division of Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 http://medicaid.utah.gov/	Toll-free: 1.800.662.9651 Local: 1.801.538.6155 *(Salt Lake City area)* Mon. – Fri. 8 a.m. – 5 p.m. Thurs. 11 a.m. – 5 p.m. Closed holidays
Vermont	Green Mountain Care Health Access Member Services Department of Vermont Health Access 280 State Drive Waterbury, VT 05671-1010 http://www.greenmountaincare.org/	Local: 1.800.250.8427 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m. Closed holidays

State Medicaid Offices
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State:	Agency Address \ Website:	Telephone \ Hours:
Virginia	Department of Medical Assistance Services 600 East Broad Street Richmond, VA 23219 http://www.dmas.virginia.gov/	Toll-free: 1.855.242.8282 TDD: 1.888.221.1590 Mon. – Fri. 8 a.m. – 7 p.m. Sat. 9 a.m. – 12 p.m.
Washington	Washington State Health Care Authority Cherry Street Plaza 626 8th Avenue SE Olympia, WA 98501 http://www.hca.wa.gov/medicaid/Pages/index.aspx	Toll-free: 1.800.562.3022 TTY: 711 Mon. – Fri. 7 a.m. – 5 p.m. Closed holidays
West Virginia	Department of Health and Human Resources Bureau for Medical Services 350 Capitol Street, Room 251 Charleston, WV 25301 http://www.dhhr.wv.gov/bms/Pages/default.aspx	Local: 1.304.558.1700 Mon. – Fri. 7 a.m. – 7 p.m.
Wisconsin	Department of Health Services 1 West Wilson Street Madison, WI 53703 http://www.dhs.wisconsin.gov/	Toll-free: 1.800.362.3002 TTY: 711 Mon. – Fri. 8 a.m. – 4 p.m.
Wyoming	Wyoming Department of Health 122 W 25th St., 4th Floor West Cheyenne, WY 82001 http://www.health.wyo.gov/healthcarefin/medicaid/	Toll-free: 1.855.294.2127 TTY: 1.855.329.5204 Mon. – Fri. 7 a.m. – 6 p.m. Closed holidays

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711. The information in this Appendix is current as of 08/05/2021.		
State:	**Agency Address \ Website:**	**Telephone \ Hours:**
Colorado	Bridging the Gap Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246-1530 https://cdphe.colorado.gov/state-drug-assistance-program	Local: 1.303.692.2716 Mon. – Fri. 9 a.m. – 5 p.m.
Delaware	Chronic Renal Disease Program (CRDP) Milford State Service Center at Riverwalk 253 NE Front Street Milford, DE 19963 www.dhss.delaware.gov/dhss/dmma/crdprog.html	Toll-free: 1.800.464.4357 *(in-state only)* Local: 1.302.424.7180 Mon. – Fri. 8 a.m. – 4:30 p.m.
Delaware	Delaware Prescription Assistance Program P.O. Box 950 New Castle, DE 19720 http://dhss.delaware.gov/dhss/dmma/dpap.html	Toll-free: 1.844.245.9580 *(option 2)* Mon. – Fri. 8 a.m. – 4:30 p.m.
Idaho	Idaho AIDS Drug Assistance Program (IDAGAP) Department of Health and Welfare Idaho Ryan White Part B Program 450 West State Street, 4th Floor P.O. Box 83720 Boise, ID 83720-0036 http://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx	Toll-free: 1.800.926.2588 Local: 1.208.334.5612 TTY/TDD: 1.208.332.7205 Mon. – Fri. 8 a.m. – 5 p.m.
Indiana	HoosierRx P.O. Box 6224 Indianapolis, IN 46206-6224 https://payingforseniorcare.com/pharmaceutical-assistance/in-hoosierrx.html	Toll-free: 1.866.267.4679 Local: 1.317.234.1381 Mon. – Fri. 7 a.m. – 3 p.m.
Maine	Low Cost Drugs for the Elderly and Disabled Program (DEL) Office of Aging & Disability Services Maine Department of Health and Human Services 11 State House Station 41 Anthony Avenue Augusta, ME 04333 http://www.maine.gov/dhhs/oads/	Toll-free: 1.800.262.2232 Local: 1.207.287.9200 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.

State Pharmaceutical Assistance Programs (SPAPs)
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State:	Agency Address \ Website:	Telephone \ Hours:
Maryland	Maryland Senior Prescription Drug Assistance Program (SPDAP) c/o International Software Systems, Inc. P.O. Box 749 Greenbelt, MD 20768-0749 http://marylandspdap.com	Toll-free: 1.800.551.5995 TTY: 1.800.877.5156 Mon. – Fri. 8 a.m. – 5 p.m.
Maryland	Kidney Disease Program 201 West Preston Street, Room SS-3 Baltimore, MD 21201 https://mmcp.health.maryland.gov/familyplanning/Pages/kidneydisease.aspx	Local: 1.410.767.5000 Mon. – Fri. 8:30 a.m. – 5 p.m. (except state holidays)
Massachusetts	Prescription Advantage P.O. Box 15153 Worcester, MA 01615-0153 www.prescriptionadvantagema.org	Toll-free: 1.800.243.4636 *(option 3)* TTY: 1.877.610.0241 Mon. – Fri. 9 a.m. – 5 p.m.
Missouri	Missouri Rx Plan P.O. Box 6500 Jefferson City, MO 65102-6500 www.payingforseniorcare.com/missouri/missouri-rx-plan	Toll-free: 1.800.375.1406 Mon. – Fri. 7 a.m. – 6 p.m.
Montana	Big Sky Rx Program P.O. Box 202915 Helena, MT 59620-2915 www.bigskyrx.mt.gov	Toll-free: 1.866.369.1233 Local: 1.406.444.1233 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Montana	Mental Health Services Plan (MHSP) Addictive and Mental Disorders Division 100 North Park Avenue, Suite 300, P.O. Box 202905 Helena, MT 59620-2905 http://dphhs.mt.gov/amdd/Mentalhealthservices/MHSP	Toll-free: 1.888.866.0328 Local: 1.406.444.3964 Mon. – Fri. 8 a.m. – 5 p.m.
Montana	Department of Public Health and Human Services HIV/STD/Viral Hepatitis Prevention Bureau Cogswell Building 1400 E. Broadway, Room C-211 Helena, MT 59620 https://dphhs.mt.gov/publichealth/hivstd	Local: 1.406.444.3565 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.

State Pharmaceutical Assistance Programs (SPAPs)
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State:	Agency Address \ Website:	Telephone \ Hours:
Nevada	Senior Rx Program Department of Health and Human Services Aging and Disability Services Division 1860 E. Sahara Ave. Las Vegas, NV 89104 http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/	Toll-free: 1.866.303.6323 *(option 2)* Local: 1.775.687.4210 *(Reno, Carson City, Gardnerville)* Mon. – Fri. 8 a.m. – 5 p.m.
New Jersey	New Jersey Department of Human Services Pharmaceutical Assistance to the Aged and Disabled (PAAD), Lifeline and Special Benefit Programs Senior Gold Prescription Discount Program (Senior Gold) P.O. Box 715 Trenton, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/services/seniorgold/ or http://www.state.nj.us/humanservices/doas/services/paad/	Toll-free: 1.800.792.9745 24 hours/7 days, automated system
New York	Elderly Pharmaceutical Insurance Coverage (EPIC) P.O. Box 15018 Albany, NY 12212-5018 www.health.ny.gov/health_care/epic/	Toll-free: 1.800.332.3742 TTY: 1.800.290.9138 Mon. – Fri. 8:30 a.m. – 5 p.m.
North Carolina	North Carolina HIV SPAP 1902 Mail Service Center Raleigh, NC 27699-1902 http://epi.publichealth.nc.gov/cd/hiv/hmap.html or http://www.ramsellcorp.com/individuals/nc.aspx	Toll-free: 1.877.466.2232 *(in-state only)* Local: 1.919.733.9161 Mon. – Fri. 8 a.m. – 5 p.m.
Pennsylvania	Chronic Renal Disease Program Pennsylvania Department of Health Eligibility Unit P.O. Box 8811 Harrisburg, PA 17105-8811 http://www.health.pa.gov/spbp	Toll-free: 1.800.225.7223 TTY: 1.800.222.9004 Mon. – Fri. 8:30 a.m. – 5 p.m.
Pennsylvania	PACE/PACENET Program Bureau of Pharmaceutical Assistance P.O. Box 8807 Harrisburg, PA 17105-8807 https://pacecares.magellanhealth.com/	Toll-free: 1.800.225.7223 TTY: 1.800.222.9004 Mon. – Fri. 8:30 a.m. – 5 p.m.

State Pharmaceutical Assistance Programs (SPAPs)
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State:	Agency Address \ Website:	Telephone \ Hours:
Pennsylvania	Special Pharmaceutical Benefits Program (SPBP) P.O. Box 8808 Harrisburg, PA 17105-8808 https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx	Toll-free: 1.800.922.9384 TTY: 1.800.222.9004 Mon. – Fri. 8:30 a.m. – 5 p.m.
Rhode Island	Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) Program Attn: RIPAE, Rhode Island Department of Human Services Office of Healthy Aging 57 Howard Avenue, Louis Pasteur Building, 2nd Floor Cranston, RI 02920 http://oha.ri.gov/	Local: 1.401.462.3000 TTY: 1.401.462.0740 Mon. – Fri. 8:30 a.m. – 4 p.m.
Texas	Kidney Health Care Program (KHC) Office of Primary and Specialty Health, MC 1938 P.O. Box 149347 Austin, TX 78714-9347 https://hhs.texas.gov/services/health/kidney-health-care	Toll-free: 1.800.222.3986 Local: 1.512.776.7150 TTY: 1.800.735.2989 or 711 Mon. – Fri. 8 a.m. – 5 p.m.
U.S. Virgin Islands	St. Thomas/St. John Office Department of Human Services Knud Hansen Complex 1303 Hospital Ground Suite 10 St. Thomas, VI 00802 Department of Human Services 3011 Golden Rock, Christiansted St. Croix, VI 00820 https://doh.vi.gov/	Local: 1.340.774.9000 *(St. Thomas)* 1.340.718.1311 *(St. Croix)* 1.340.776.6334 *(St. John)* Mon. – Fri. 8 a.m. – 5 p.m.
Vermont	VPharm/Healthy Vermonters 280 State Drive Waterbury, VT 05671-1500 https://www.payingforseniorcare.com/vermont/vpharm-vhap-vscript	Toll-free: 1.800.250.8427 TTY: 1.888.834.7898 Mon. – Fri. 8 a.m. – 4:30 p.m.

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.		
State:	**Agency Address \ Website:**	**Telephone \ Hours:**
Virginia	Virginia AIDS Drug Assistance Program (ADAP) and Virginia HIV SPAP, Patient Services Incorporated P.O. Box 5930 Midlothian, VA 23112 http://q1medicare.com/PartD-SPAPVirginiaStatePharmAssistPrgm.php	Toll-free: 1.800.366.7741 Monday, Tuesday, Thursday & Friday 8:30 a.m. to 5 p.m. Wednesday 9:30 a.m. to 5 p.m.
Washington	Washington State Health Insurance Pool (WSHIP) P.O. Box 1090 Great Bend, KS 67530 https://www.wship.org/Default.asp	Toll-free: 1.800.877.5187 Mon. – Fri. 8 a.m. – 5 p.m.
Wisconsin	Wisconsin Chronic Disease Program Attn: Eligibility Unit P.O. Box 6410 Madison, WI 53716-0410 https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm	Toll-free: 1.800.362.3002 Mon. – Fri. 8 a.m. – 6 p.m.
Wisconsin	Wisconsin SeniorCare P.O. Box 6710 Madison, WI 53716-0710 www.dhs.wisconsin.gov/seniorcare	Toll-free: 1.800.657.2038 TTY: 711 Mon. – Fri. 8 a.m. – 6 p.m.

AIDS Drug Assistance Programs
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The information in this Appendix is current as of 08/05/2021.

State:	Agency Address \ Website:	Telephone \ Hours:
Alabama	Alabama AIDS Drug Assistance Program Alabama Department of Public Health Office of HIV Prevention and Care, The RSA Tower 201 Monroe Street, Suite 1400 Montgomery, AL 36104 http://www.alabamapublichealth.gov/hiv/adap.html	Toll-free: 1.866.574.9964 Mon. – Fri. 8 a.m. – 5 p.m. (except state holidays)
Alaska	Alaskan Aids Assistance Association 1057 W. Fireweed Lane, Suite 102 Anchorage, AK 99503 http://www.alaskanaids.org/	Toll-free: 1.800.478.2437 Local: 1.907.263.2050 Mon. – Fri. 9 a.m. – 5 p.m.
American Samoa	American Samoa Department of Public Health LBJ Tropical Medical Center, P.O. Box F Pago Pago, AS 96799 https://www.nastad.org/membership-directory/search?tid=1123	Local: 1.684.633.4071
Arizona	Arizona Department of Health Services 150 N. 18th Avenue, Suite 110 Phoenix, AZ 85007 https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php	Toll-free: 1.800.334.1540 Local: 1.602.364.3610 Mon. – Fri. 8 a.m. – 5 p.m. (except state holidays)
Arkansas	Arkansas Department of Health Ryan White Program – Part B 4815 W. Markham St., Slot 33 Little Rock, AR 72205 https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-faqs	Toll-free: 1.800.462.0599 Local: 1.501.661.2408 Mon. – Fri. 8 a.m. – 4:30 p.m.
California	Office of AIDS Center for Infectious Diseases California Department of Public Health MS 7700, P.O. Box 997426 Sacramento, CA 95899-7426 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx	Toll-free: 1.844.421.7050 Local: 1.916.558.1784 Mon. – Fri. 8 a.m. – 5 p.m. (excluding holidays)

AIDS Drug Assistance Programs
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State:	Agency Address \ Website:	Telephone \ Hours:
Colorado	Colorado Department of Public Health & Environment ADAP Enrollment – A3 4300 Cherry Creek Drive South Denver, CO 80246 https://www.colorado.gov/pacific/cdphe/state-drug-assistance-program	Local: 1.303.692.2716 Mon. – Fri. 9 a.m. – 5 p.m.
Connecticut	State of Connecticut Department of Public Health c/o Magellan Rx P.O. Box 13001 Albany, NY 12212-3001 https://ctdph.magellanrx.com/	Toll-free: 1.800.424.3310 Mon. – Fri. 8 a.m. – 4 p.m.
Delaware	Division of Public Health, Ryan White Program Thomas Collins Building 540 S. DuPont Highway Dover, DE 19901 http://dhss.delaware.gov/dph/dpc/hivtreatment.html	Local: 1.302.744.1050 Mon. – Fri. 8 a.m. – 4:30 p.m.
District of Columbia	DC ADAP DC Department of Health 899 North Capitol Street, NE Washington, DC 20002 https://dchealth.dc.gov/node/137072	Local: 1.202.671.4900 TTY: 711 Mon. – Fri. 8:15 a.m. – 4:45 p.m. (except District holidays)
Florida	Florida Department of Health HIV/AIDS Section AIDS Drug Assistance Program 4052 Bald Cypress Way, BIN A09 Tallahassee, FL 32399 http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	Toll-free: 1.800.352.2437 TTY: 1.888.503.7118 Mon. – Fri. 8 a.m. – 5 p.m.
Georgia	Georgia Department of Public Health Office of HIV/AIDS 2 Peachtree Street, NW Atlanta, GA 30303 https://dph.georgia.gov/office-hivaids	Local: 1.404.657.3100 Mon. – Fri. 8 a.m. – 5 p.m.

AIDS Drug Assistance Programs
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State:	Agency Address \ Website:	Telephone \ Hours:
Guam	Department of Public Health and Social Services Bureau of Communicable Disease Control STD/HIV Program, Room 156 123 Chalan Kareta Mangilao, GU 96913 http://dphss.guam.gov/content/contact-us	Local: 1.671.735.7166
Hawaii	Hawaii Department of Health Harm Reduction Services Branch HIV Medical Management Services 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816 http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/	Local: 1.808.733.9360 TTY: 711 Mon. – Fri. 7:45 a.m. – 4:30 p.m. (except state holidays)
Idaho	Idaho AIDS Drug Assistance Program Department of Health and Welfare Idaho Ryan White Part B Program 450 West State Street, 4th Floor P.O. Box 83720 Boise, ID 83720-0036 http://healthandwelfare.idaho.gov/Health/FamilyPlanning,STDHIV/HIVCareandTreatment/tabid/391/Default.aspx	Toll-free: 1.800.926.2588 Local: 1.208.334.5612 TTY/TDD: 1.208.332.7205 Mon. – Fri. 8 a.m. – 5 p.m.
Illinois	Illinois Department of Public Health Ryan White Part B Program 525 W. Jefferson Street, 1st Floor Springfield, IL 62761 https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services	Toll-free: 1.800.825.3518 Local: 1.217.524.5983 TTY: 1.800.547.0466 Mon. – Fri. 8 a.m. – 4 p.m.
Indiana	Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 http://www.in.gov/isdh/17740.htm	Toll-free: 1.866.588.4948 Mon. – Fri. 8:15 a.m. – 4:45 p.m.
Iowa	Iowa Department of Public Health 321 East 12th Street Des Moines, IA 50319-0075 http://idph.iowa.gov/hivstdhep/hiv/support	Local: 1.515.281.7689 TTY: 711 Mon. – Fri. 8 a.m. – 4:30 p.m.

AIDS Drug Assistance Programs
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State:	Agency Address \ Website:	Telephone \ Hours:
Kansas	Kansas Department of Health & Environment 1000 SW Jackson, Suite 210 Topeka, KS 66612 http://www.kdheks.gov/sti_hiv/ryan_white_care.htm	Local: 1.785.296.1982 Mon. – Fri. 8 a.m. – 5 p.m.
Kentucky	Kentucky Department for Public Health Cabinet for Health and Family Services HIV/AIDS Branch 275 East Main Street, HS2E-C Frankfort, KY 40621 https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	Toll-free: 1.866.510.0005 Mon. – Fri. 8 a.m. – 4:30 p.m.
Louisiana	Louisiana Office of Public Health Louisiana Health Access Program 1450 Poydras Street, Suite 2136 New Orleans, LA 70112 https://www.lahap.org/	Local: 1.504.568.7474 Mon. – Fri. 8 a.m. – 5 p.m.
Maine	Maine Center For Disease Control and Prevention AIDS Drug Assistance Program 286 Water Street, 6th Floor 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/aids-drug-assist.shtml	Toll-free: 1.800.821.5821 Local: 1.207.287.3747 TTY: 711 Mon. – Fri. 8 a.m. – 5 p.m.
Maryland	Maryland Department of Health and Mental Hygiene Maryland AIDS Drug Assistance Program (MADAP) 201 West Preston Street Baltimore, MD 21201-2399 https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx	Toll-free: 1.800.205.6308 Local: 1.410.767.6535 TTY: 1.800.735.2258 Mon. – Fri. 8:30 a.m. – 4:30 p.m.
Massachusetts	Community Research Initiative The Schrafft's City Center 529 Main Street, Suite 330 Boston, MA 02129 https://crine.org/hdap	Toll-free: 1.800.228.2714 Local: 1.617.502.1700 Mon. – Fri. 9 a.m. – 5 p.m.

AIDS Drug Assistance Programs
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State:	Agency Address \ Website:	Telephone \ Hours:
Michigan	Michigan Drug Assistance Program Michigan Department of Health and Human Services Division of Health, Wellness and Disease Control HIV Care Section 109 Michigan Avenue, 9th Floor Lansing, MI 48913 http://www.michigan.gov/dap	Toll-free: 1.888.826.6565 Mon. – Fri. 8 a.m. – 5 p.m.
Minnesota	HIV/AIDS Programs Department of Human Services P.O. Box 64972 St. Paul, MN 55164-0972 https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/	Toll-free: 1.800.657.3761 Local: 1.651.431.2414 TTY: 1.800.627.3529 Mon. – Fri. 8:30 a.m. – 4:30 p.m.
Mississippi	Mississippi State Department of Health Office of STD/HIV Care and Treatment Division P.O. Box 1700 Jackson, MS 39215-1700 https://msdh.ms.gov/msdhsite/_static/14,13047,150.html	Toll-free: 1.888.343.7373 Local: 1.601.362.4879 Mon. – Fri. 8 a.m. – 5 p.m.
Missouri	Bureau of HIV, STD, and Hepatitis Missouri Department of Health and Senior Services P.O. Box 570 Jefferson City, MO 65102-0570 https://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php	Toll-free: 1.866.628.9891 *(option 5)* Local: 1.573.751.6439 TTY: 1.800.735.2966 Mon. – Fri. 8 a.m. – 5 p.m.
Montana	Montana Dept. of Public Health and Human Services P.O. Box 202951 Cogswell Bldg. C-211 Helena, MT 59620-2951 https://dphhs.mt.gov/publichealth/hivstd/treatment	Local: 1.406.444.4744 Mon. – Fri. 8 a.m. – 5 p.m.
Nebraska	Nebraska Department of Health & Human Services Ryan White Program P.O. Box 95026 Lincoln, NE 68509-5026 http://dhhs.ne.gov/Pages/Ryan-White.aspx	Local: 1.402.471.2101 Mon. – Fri. 8 a.m. – 5 p.m.

AIDS Drug Assistance Programs
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State:	Agency Address \ Website:	Telephone \ Hours:
Nevada	Office of HIV Nevada Division of Public and Behavioral Health 1840 E. Sahara Avenue, Suite 110-111 Las Vegas, NV 89104 https://endhivnevada.org/end-hiv-nevada-program/nevadas-aids-drug-assistance-program-adap/	Local: 1.702.486.0768 Mon. – Fri. 8 a.m. – 5 p.m.
New Hampshire	New Hampshire Department of Health & Human Services NH CARE Program 29 Hazen Drive Concord, NH 03301 https://www.dhhs.nh.gov/dphs/bchs/std/care.htm	Toll-free: 1.800.852.3345 *extension 4502* *(in-state only)* Local: 1.603.271.4502 TTY: 1.800.735.2964 Mon. – Fri. 8 a.m. – 4:30 p.m.
New Jersey	New Jersey Department of Health AIDS Drug Distribution Program (ADDP) P.O. Box 722 Trenton, NJ 08625-0722 http://www.nj.gov/health/hivstdtb/hiv- aids/medications.shtml	Toll-free: 1.877.613.4533 Mon. – Fri. 9 a.m. – 5 p.m.
New Mexico	New Mexico Department of Health HIV Services Program 1190 S. St. Francis Drive Santa Fe, NM 87505 https://nmhealth.org/about/phd/idb/hats/	Local: 1.505.476.3628 Mon. – Fri. 8 a.m. – 5 p.m.
New York	Uninsured Care Programs Empire Station P.O. Box 2052 Albany, NY 12220-0052 https://www.health.ny.gov/diseases/aids/general/resources/adap/	Toll-free: 1.800.542.2437 or 1.844.682.4058 *(in-state only)* Out-of-state: 1.518.459.1641 TDD: 1.518.459.0121 Mon. – Fri. 8 a.m. – 5 p.m.
North Carolina	Communicable Disease Branch Epidemiology Section, Division of Public Health N.C. Dept. of Health and Human Services 1902 Mail Service Center Raleigh, NC 27699-1902 http://epi.publichealth.nc.gov/cd/hiv/program.html	Toll-free: 1.877.466.2232 *(in-state only)* Out-of-state: 1.919.733.9161 Mon. – Fri. 8 a.m. – 5 p.m.

AIDS Drug Assistance Programs
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.

State:	Agency Address \ Website:	Telephone \ Hours:
North Dakota	North Dakota DOH Division of Infectious Disease 600 E. Boulevard Ave., Dept. 301 P.O. Box 5520 Bismarck, ND 58505 https://www.ndhealth.gov/hiv/	Toll-free: 1.800.472.2180 *(in-state only)* Local: 1.701.328.2379 Mon. – Fri. 8 a.m. – 5 p.m.
Northern Mariana Islands	HIV/STD/VH Prevention Program P.O. Box 500409 Saipan, MP 96950 https://www.nastad.org/membership-directory/search?tid=1167	Local: 1.670.664.4050 Mon. – Fri. 7:30 (CHST) – 16:30 (CHST)
Ohio	Ohio Department of Health Ohio AIDS Drug Assistance Program (ADAP) HIV Client Services 246 North High Street Columbus, OH 43215 https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/	Toll-free: 1.800.777.4775 Mon. – Fri. 8 a.m. – 5 p.m.
Oklahoma	HIV/Sexual Health and Harm Reduction Services Oklahoma State Department of Health 123 Robert S. Kerr Ave. Oklahoma City, OK 73102-6406 https://oklahoma.gov/health/prevention-and-preparedness/sexual-health-and-harm-reduction-service.html	Local: 1.405.271.4636 Mon. – Fri. 8 a.m. – 5 p.m. (except holidays)
Oregon	CAREAssist Program P.O. Box 14450 Portland, OR 97293 http://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/CAREASSIST/Pages/index.aspx	Toll-free: 1.800.805.2313 Local: 1.971.673.0144 TTY: 1.971.673.6372 Mon. – Fri. 8 a.m. – 5 p.m.
Pennsylvania	Department of Health Special Pharmaceutical Benefits Program P.O. Box 8808 Harrisburg, PA 17105-8808 https://www.health.pa.gov/topics/programs/HIV/Pages/Services.aspx	Toll-free: 1.800.922.9384 Mon. – Fri. 8 a.m. – 4:30 p.m.

AIDS Drug Assistance Programs
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.

State:	Agency Address \ Website:	Telephone \ Hours:
Puerto Rico	Commonwealth of Puerto Rico Department of Health Ryan White Part B AIDS Drug Assistance Program P.O. Box 70184 San Juan, PR 00936-8184 http://www.salud.gov.pr/Dept-de-Salud/Pages/Unidades-Operacionales/Secretaria-Auxiliar-de-Salud-Familiar-y-Servicios-Integrados/Division%20Central%20de%20Asuntos%20de%20SIDA%20y%20Enfermedades%20Transmisibles/Programa-Ryan-White.aspx	Local: 1.787.765.2929 Mon. – Fri. 8 a.m. – 4:30 p.m.
Rhode Island	Executive Office of Health and Human Services Office of HIV/AIDS Virks Building, Suite 227 3 West Road Cranston, RI 02920 http://www.eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx	Local: 1.401.462.3294 Mon. – Fri. 8:00 a.m. – 3:30 p.m.
South Carolina	South Carolina AIDS Drug Assistance Program South Carolina Department of Health and Environmental Control 2600 Bull Street Columbia, SC 29201 http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/	Toll-free: 1.800.856.9954 Mon. – Fri. 8:30 a.m. – 5 p.m.
South Dakota	South Dakota Department of Health Ryan White Part B CARE Program 615 East 4th Street Pierre, SD 57501-1700 http://doh.sd.gov/diseases/infectious/ryanwhite/	Toll-free: 1.800.592.1861 Local: 1.605.773.3737 Mon. – Fri. 8 a.m. – 5 p.m.
Tennessee	Tennessee AIDS Drug Assistance Program (ADAP) Tennessee Department of Health 710 James Robertson Parkway Nashville, TN 37243 https://www.tn.gov/health/health-program-areas/std/std/ryanwhite.html	Toll-free: 1.800.525.2437 Local: 1.615.741.7500 Mon. – Fri. 7:00 a.m. – 4:30 p.m.

AIDS Drug Assistance Programs
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.

State:	Agency Address \ Website:	Telephone \ Hours:
Texas	Texas Department of State Health Services Medication Program ATTN: MSJA, MC 1873 P.O. Box 149347 Austin, TX 78714-9347 http://www.dshs.texas.gov/hivstd/meds/	Toll-free: 1.800.255.1090 TTY: 1.800.735.2989 Mon. – Fri. 8 a.m. – 5 p.m.
U.S. Virgin Islands	United States Virgin Islands Department of Health John Moorehead Complex (Old Hospital) Communicable Diseases Clinic, Building I St. Thomas, VI 00802 https://doh.vi.gov/programs/communicable-diseases	Local: 1.340.774.9000 Mon. – Fri. 8 a.m. – 5 p.m.
Utah	Utah Department of Health Bureau of Epidemiology 288 North 1460 West, P.O. Box 142104 Salt Lake City, UT 84114-2104 http://health.utah.gov/epi/treatment/	Local: 1.801.538.6197 Mon. – Fri. 8 a.m. – 5 p.m.
Vermont	Vermont Department of Health Vermont Medication Assistance Program P.O. Box 70, Drawer 41 – IDEPI Burlington, VT 05402 http://www.healthvermont.gov/immunizations-infectious-disease/hiv/care	Local: 1.802.951.4005 Local: 1.802.863.7245 Mon. – Fri. 7:45 a.m. – 4:30 p.m.
Virginia	Virginia Department of Health HCS Unit, 1st Floor 109 Governor Street Richmond, VA 23219 http://www.vdh.virginia.gov/disease-prevention/eligibility/	Toll-free: 1.855.362.0658 Mon. – Fri. 8 a.m. – 5 p.m.
Washington	EIP Client Services P.O. Box 47841 Olympia, WA 98504-7841 https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP	Toll-free: 1.877.376.9316 *(in-state only)* Local: 1.360.236.3475 Mon. – Fri. 8 a.m. – 5 p.m. (except state holidays)

AIDS Drug Assistance Programs
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, you may try 711.

State:	Agency Address \ Website:	Telephone \ Hours:
West Virginia	West Virginia Department of Health and Human Resources Office of Epidemiology and Preventive Services 350 Capitol Street, Room 125 Charleston, WV 25301 https://oeps.wv.gov/Pages/default.aspx	Local: 1.304.558.2195 Mon. – Fri. 9 a.m. – 5 p.m.
Wisconsin	Department of Health Services Division of Public Health, Attn: ADAP P.O. Box 2659 Madison, WI 53701 https://www.dhs.wisconsin.gov/aids-hiv/adap.htm	Toll-free: 1.800.991.5532 TTY: 1.800.947.3529 Mon. – Fri. 8 a.m. – 4:30 p.m.
Wyoming	Wyoming Department of Health Public Health Division Communicable Disease Treatment Program 6101 Yellowstone Road Cheyenne, WY 82002 https://health.wyo.gov/publichealth/communicable-disease-unit/hiv/resources-for-patients/	Local: 1.307.777.5856 Mon. – Fri. 8 a.m. – 5 p.m.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

E00SES2A

EXPLANATION OF PAYMENT

EXPRESS SCRIPTS®
Medicare (PDP)
PO BOX 66581, St. Louis, MO 63166-6581

EXPLANATION OF PAYMENT

0-E-001709-001-01-04
LAST NAME FIRST NAME
10 SAMPLE DRIVE
ANY TOWN ST 99999

Member Number:	XXXXXXXXXX
Group Number:	GRP NUMBER
Check Date/Check No.:	09/07/2018 - XXXXXXXXX
Benefit Starting Date:	01/01/9999
Provider:	PROVIDER NAME
Carrier Number:	XXXX

Date of Service	Rx Number	Amount Submitted	Amount Approved	Deductible Applied	Copay Applied	Adjusted Amount	Total Payable	Explanation Codes
FIRST NAME								
10/01/2016	XXX0001	500.00	40.84	25.00	1.58	459.16	14.26	W S WA
SPENDING ACCOUNT APPLIED			APPLIED FOR THIS CLAIM IS		$0.00			
PATIENT TOTAL		500.00	40.84	25.00	1.58	459.16	14.26	

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

OT40398D

ICWCE6 (REV.5 02/17)

EXPRESS SCRIPTS®
One Express Way
St. Louis, MO 63121

Fifth Third Bank
Northern Kentucky

123456789

73-27
421

GROUP NO.	MEMBER NO.	DATE
GROUP NAME	XXXXXXXXXX	09/07/2018

VOID

AMOUNT
*********$14.26

Non-negotiable after 180 days.

VOID

PAY **Fourteen and 26/100** **********

TO THE ORDER OF **LAST NAME FIRST NAME**

VOID VOID

Authorized Signature

This benefit provided by XXXXX XX XXXXXXX

⑈999999999⑈ ⑆999999999⑆ 999999999⑈

Reimbursement Amount. Reimbursement will be made according to the limits of your prescription benefit plan and reflect the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

You have the right to appeal. You must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Who May Request an Appeal? You, your prescriber or your representative may request an appeal. You can name a relative, friend, advocate, attorney, doctor or someone else to be your representative. Others may already be authorized under State law to be your representative. For questions regarding how to file an appeal, call the number on the back of your member ID card.

Definition of Terms

Date Of Service	Date the prescription was dispensed at your pharmacy.	**Copay Applied**	The portion of the Amount Approved for which you are responsible after your deductible has been satisfied.
Rx Number	The number assigned by the dispensing pharmacy.	**Adjusted Amount**	The difference between the Amount Submitted and the Amount Approved.
Amount Submitted	The amount you paid for your prescription.	**Total Payable**	Amount Approved minus the Deductible Applied minus the Copay Applied.
Amount Approved	The portion of the Amount Submitted which is covered by your plan.		
Deductible Applied	The portion of the Amount Approved applied to your plan deductible. Claim amounts are applied in the order they are processed even though they may be listed by Date of Service on this form.	**Explanation Codes**	The Explanation Codes used on this form are defined at the end of the claim detail.

If a claim does not appear on this statment and was submitted at the same time, you will receive a letter of explanation under separate cover.

EXPRESS SCRIPTS®
Medicare (PDP)
PO BOX 66581, St. Louis, MO 63166-6581

EXPLANATION OF PAYMENT

0-E-001709-001-02-04
LAST NAME FIRST NAME

Member Number:	XXXXXXXXXX
Group Number:	GRP NUMBER
Check Date/Check No.:	09/07/2018 - XXXXXXXXX
Benefit Starting Date:	01/01/9999
Provider:	PROVIDER NAME
Carrier Number:	XXXX

Date of Service	Rx Number	Amount Submitted	Amount Approved	Deductible Applied	Copay Applied	Adjusted Amount	Total Payable	Explanation Codes
STATEMENT TOTAL		500.00	40.84	25.00	1.58	459.16	14.26	

EXPLANATION CODES:

S - You have been reimbursed only the amount that your plan would have paid this participating retail pharmacy. Next time, be sure to present your prescription drug ID card at the time of purchase.
W - The cost submitted for this medication is more than what your plan allows. You have been reimbursed only up to what your plan allows.
WA - Submit Amt reduced to Amt Allowed due to contract

ACCOUNT SUMMARY:

	CURRENT STATEMENT			YEAR TO DATE		
PATIENT	DEDUCTIBLE APPLIED	CAP APPLIED	OUT-OF-POCKET APPLIED	DEDUCTIBLE REMAINING	CAP REMAINING	OUT-OF-POCKET REMAINING
FIRST NAME	N/A	N/A	N/A	N/A	N/A	N/A

SPENDING ACCOUNT APPLIED APPLIED: $0.00 ; YEAR TO DATE REMAINING $0.00

'N/A' MEANS NOT APPLICABLE TO PLAN.

OUR RECORDS INDICATE THAT THE FOLLOWING PHARMACIES WERE USED:

XXXX XXXXXXX XXXXXXXXX XXXX

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. Enrollment in Express Scripts Medicare depends on contract renewal.

OT40398D

ICWPD9 (REV.5 06/16)

It's important we treat you fairly

Our goal is to treat you fairly. We do not view or treat people differently because of their race, color, national origin, sex, age or if they have a disability. If you need our help with any of the information we send you, please let us know. We have services that may help you. These can include aids, interpreters and information written in other languages. These are free at no charge to you. If you are in need of any of these services, please call us. You can reach us at the number on the back of your member ID card. If you feel we didn't offer you these services, please let us know. If you feel we didn't treat you fairly because of your race, color, national origin, sex, age or disability, let's talk about it. We are here for you. You can also file a grievance. This is also known as a complaint. To file a complaint, please contact:

Civil Rights Coordinator
at Express Scripts Medicare, P.O. Box 4083, Dublin, OH 43016

You can also contact the U.S. Department of Health and Human Services, Office for Civil Rights at:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

Albanian: Kemi shërbime përkthyesi falas për t'iu përgjigjur çdo pyetje që mund të keni mbi planin tonë shëndetësor ose të ilaçeve. Për të marë një përkthyes, thjesht na telefononi në numrat në pjesën e pasme të kartës suaj Identifikuese të Anëtarit. Dikush që flet shqip mund t'ju ndihmojë. Ky është një shërbim falas.

Arabic: إنّنا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري, ليس عليك سوى الاتصال بنا على الأرقام الموجودة على ظهر بطاقة هوية العضو. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Bengali:
বাংলা: আমাদের স্বাস্থ্য বা ওষুধ সংক্রান্ত পরিকল্পনার বিষয়ে আপনার যে কোনো প্রশ্নের উত্তর দেওয়ার জন্য আমাদের বিনামূল্যে দোভাষী পরিষেবা আছে। একজন দোভাষী পেতে, আপনার সদস্য আই-ডি কার্ডের পিছনে দেওয়া নম্বরগুলিতে আমাদের ফোন করুন। বাংলাভাষী কোনো ব্যক্তি আপনাকে সাহায্য করতে পারে। এটি একটি বিনামূল্যে পরিষেবা।

Cambodian-Mon-Khmer:
ខ្មែរមនកម្ពុជា: យើងមានផ្តល់ជូនខ្លួរសេវាបកប្រែផ្តាល់មាត់ឥតគិតថ្លៃ ដើម្បីឆ្លើយសំណួរអ្សែង។ ដែលលោកអ្នកអាចមានអំពីគម្រោងសុខភាព ឬឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្តាល់មាត់ម្នាក់ គ្រាន់តែទូរស័ព្ទមកយើងតាមលេខនៅខាងខ្នងប័ណ្ណសម្គាល់សមាជិករបស់លោកអ្នក។ អ្នកដែលចេះនិយាយភាសាខ្មែរមនកម្ពុជាអាចជួយលោកអ្នកបាន។ នេះគឺជាសេវាឥតគិតថ្លៃ។

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电您会员 ID 卡背面的号码。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電您會員 ID 卡背面的號碼。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler aux numéros figurant au dos de votre carte de membre. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter den Nummern auf der Rückseite Ihrer Mitgliedskarte. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Greek: Διαθέτουμε δωρεάν υπηρεσίες διερμηνέα για να απαντήσουμε σε ερωτήσεις που μπορεί να έχετε σχετικά με την υγεία σας ή με το φαρμακευτικό μας πρόγραμμα. Για να συνδεθείτε με κάποιον διερμηνέα, απλά καλέστε μας στους αριθμούς που βρίσκονται στο πίσω μέρος της κάρτας μέλους σας (Member ID). Κάποιος που μιλάει Ελληνικά θα μπορέσει να σας βοηθήσει. Αποτελεί δωρεάν υπηρεσία.

Gujarati:
ગુજરાતી: અમે તમારા આરોગ્ય અથવા દવાની યોજના વિશે તમારા કોઈપણ પ્રશ્નોનાં જવાબ આપવા માટે મફત દુભાષિયાની સેવાઓ આપીએ છીએ. દુભાષિયાની સેવા મેળવવા માટે તમારા મેમ્બર ID કાર્ડની પાછળ આપેલા નંબરો પર અમને કોલ કરો. કોઈ ગુજરાતી બોલી શકતી વ્યક્તિ તમારી મદદ કરી શકે છે. આ મફત સેવા છે.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan nimewo yo dèyè ka ID Manm ou. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare i numeri sul retro della vostra tessera identificativa di socio. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 가입자 ID 카드 뒷면의 전화 번호로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Pennyslvania Dutch:
Deitsch: Mir hen free Iwwersetzer Services um dei Frooge zu andwatte, die du vielleicht iwwer dei Gsundheit odder Drug Blan hoscht. Um en Iwwersetzer zu griege, ruf uns um die Nurnmer uff die Rickseit vun dei Member ID Kaarde aa. Epper der Deitsch schwetzt, kann dir helfe. Des iss en Free Service.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numery znajdujące się na odwrocie członkowskiej karty identyfikacyjnej. Ta usługa jest bezpłatna.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através dos números no verso do seu cartão de ID de membro. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номерам телефонов на оборотной стороне идентификационной карточки участника. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame a los números que figuran en el dorso de su tarjeta de identificación. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa numerong nasa likod ng iyong Miyembrong ID card. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Urdu: صحت یا دوا سے متعلق ہمارےم نصوبے کے بارے میں آپ کے کسی بھی مکمنہ سوال کا جواب دینے کے لئے
ہما ےر یہاں ترجنمای کی مفت خدمات دستیاب ہیں ک۔ سی ترجامن کی خدمات حاصل کرنے کے لیے، آ پ بس ا پنے ممبر
شنتایخ کارڈ کی پش تپر درج تمبرو نپر ہمیں کال کریں۔ اردوب ولنے والا کوئی شخص آ پکی مدد کرسکتا ہے۔ یہ ا یک
مفت خدمت ہے۔

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi các số điện thoại ở mặt sau thẻ ID Hội Viên của quý vị. Sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

Yiddish:
אידיש: מיר האבן אומזיסטע דאלמעטשער סערוויסעס צו ענטפערן סיי וועלכע פראגעס וואס איר קענט מעגליך האבן איבער אונזער העלט אדער דראג פלאן. כדי צו באקומען א דאלמעטשער, פשוט רופט אונז אויף די נומערן אויף די הינטערשטע זייט פון אייער מיטגליד אידענטיטעט קארטל. עמיצער וואס רעדט אידיש קען אייך העלפן. דאס איז אן אומזיסטע סערוויס.

THANK YOU

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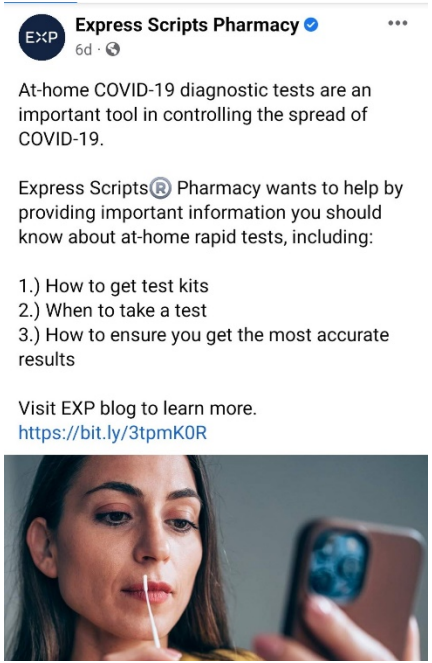
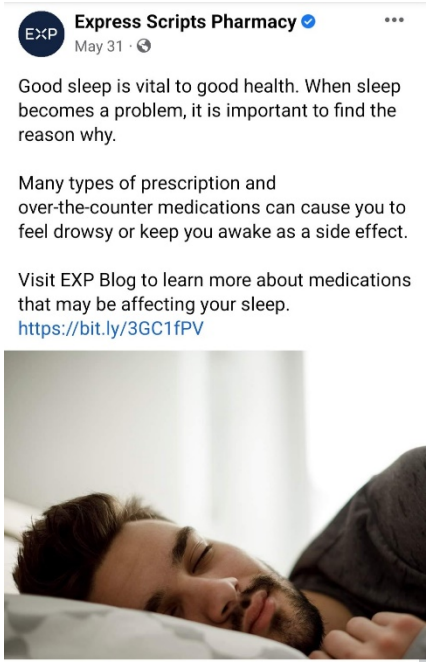
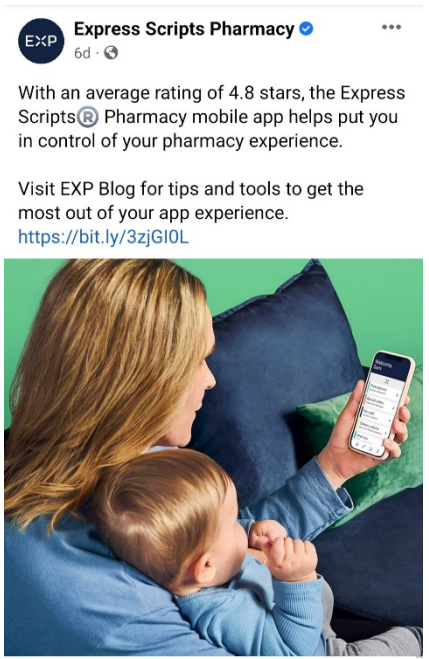
While Express Scripts does not provide specific content to our clients for their Facebook pages, we do encourage both clients and members to follow us on social media platforms and share our posts.







EXPRESS SCRIPTS®

EXPRESS SCRIPTS®

Coverage for your medication is about to change.

This is a reminder that on (Effective date) your plan will no longer cover one or more of your medications. Don't wait to make a change.

Hello X,

Our doctors and pharmacists regularly check the list of medications covered by your plan to make sure they are safe, effective, and affordable.

After (effective date) one or more of your medications will no longer be covered by your plan. This means you will pay full price for your medication if you don't move to a covered alternative.

Your Current Medication(s)*

ORACEA

Rx #: XXXXXXXXXXX

Covered Alternatives:**

- doxycycline hyclate
- doxycycline monohydrate
- azelaic acid
- ivermectin cream
- metronidazole topical

Here's what you can do:

Ask your doctor about prescribing a covered alternative.

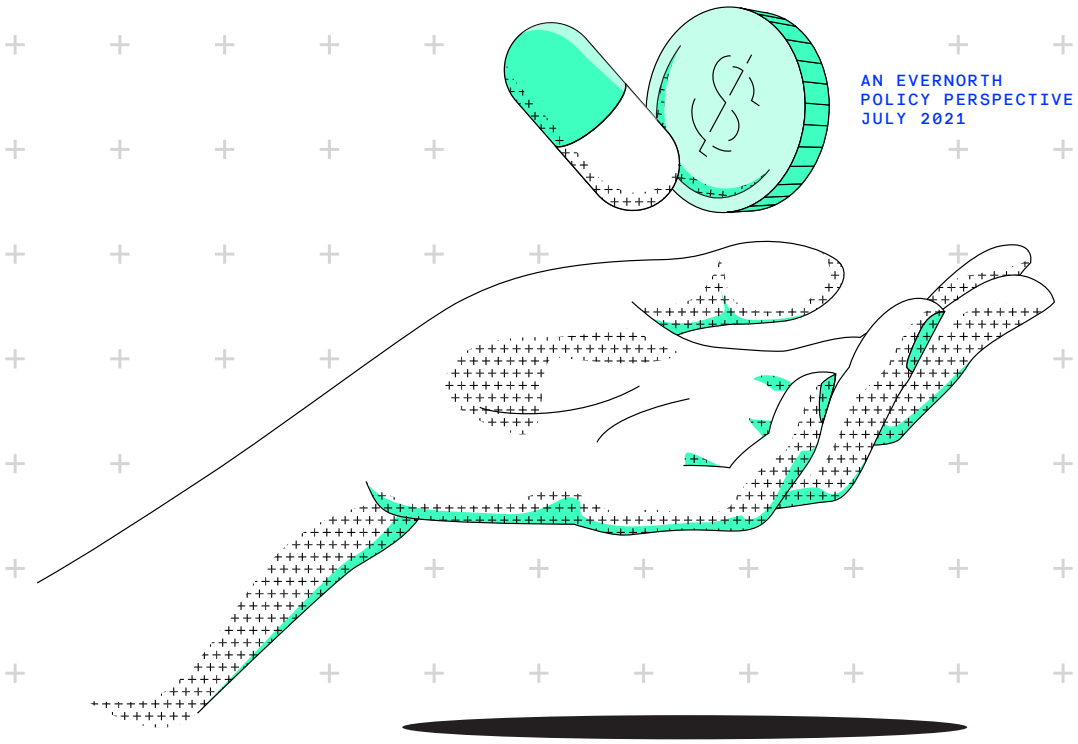
After (effective date) you'll be able to compare medication prices with your changing coverage.

*If your doctor provided a prior approval for your medication, it may expire. You may need to talk to your doctor about getting a covered alternative approved. If there is a clinical reason identified by your doctor that requires you to continue taking your current medication, please ask your doctor to contact Express Scripts.

**Additional covered alternatives may be available. Other prescription plan considerations may apply. Costs for covered alternatives may vary. When applicable to some plans, the cost of the current medication may not be applied to your deductible or out-of-pocket maximum.

EMPLOYER GROUP WAIVER PLANS (EGWPs)
ARE AT RISK

HELP RETIREES KEEP THEIR COVERAGE



AN EVERNORTH
POLICY PERSPECTIVE
JULY 2021

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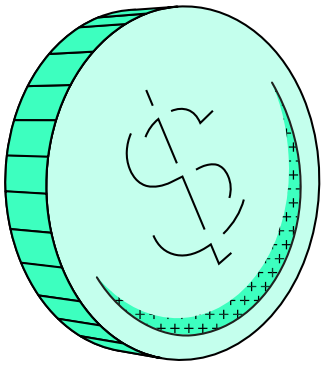
PROTECT HIGH-QUALITY, AFFORDABLE MEDICARE COVERAGE



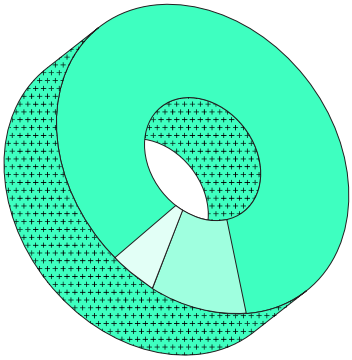
Drug pricing reforms currently under consideration will have unintended consequences—threatening EGWPs in Part D and creating a windfall for drug manufacturers

Many employers and unions provide Medicare Part D coverage to eligible retirees through dedicated plans known as Employer Group Waiver Plans (EGWPs). EGWPs offer tremendous value to retirees, employers, retirement systems and unions—as well as to Medicare—by improving access and affordability for patients at a low cost to the federal government. These plans must provide benefits that are at least the same as those offered by other Medicare plans. In addition, they provide flexibilities that allow coverage customized to support each employer's retiree benefit commitments.

As policymakers focus on lowering drug prices and reforming the Part D program, many of the reforms under consideration will have unintended consequences that both threaten EGWPs in Part D and create a windfall for drug manufacturers.

What to know about EGWPs

Under the Part D program, Medicare beneficiaries can purchase prescription drug coverage offered by private health or prescription drug plans in their area. Employers, retirement systems and unions can also provide Medicare Advantage and Part D coverage to their Medicare-eligible retirees through dedicated plans known as Employer Group Waiver Plans (EGWPs).



There are currently 7.4M retirees enrolled in EGWPs, representing 15% of the nearly 49M Part D beneficiaries

Since the enactment of the Affordable Care Act (ACA), more employers have been offering drug benefits to retirees through EGWPs, largely due to the ACA's creation of the Coverage Gap Discount Program (CGDP) and the elimination of the tax deduction for employers receiving the Retiree Drug Subsidy (RDS).

Prior to the passage of the ACA, employers were able to deduct the subsidies reimbursed by the federal government through the RDS program from their taxable incomes. However, starting in 2013, plan sponsors were no longer permitted to deduct health benefit costs reimbursed by the RDS program, eliminating its once tax-free status and making EGWPs more desirable to retiree benefit providers. In addition, under Governmental Accounting Standards Board accounting, future subsidies cannot be used to offset liabilities for future benefits. As such, the RDS program does not impact liability and, therefore, does not allow for state and local governments to recognize the value of these subsidies in the Other Post-Employment Benefits (OPEB) actuarial funding calculations. For example, Teachers' Retirement System of the State of Kentucky has been able to reduce their OPEB liability by $1.9 billion due to enrolling retirees in EGWPs for Part D and Medicare Advantage.

The elimination of the tax-favored treatment of the RDS plan, combined with the increase in manufacturer contribution through the CGDP, made EGWPs a more attractive option for many employers, retirement systems and trusts. As a result, the number of enrollees in RDS plans has declined considerably, from 6.8M in 2010 to 1.4M in 2019, while enrollment in EGWPs has increased from 2.4M to 7M over the same period.[1] There are currently 7.4M retirees enrolled in EGWPs, representing 15% of the nearly 49M Part D beneficiaries. The majority (4.5M) of EGWPs are stand-alone Prescription Drug Plans (PDP), while 2.8M are Medicare Advantage Prescription Drug (MA-PD) plans. California, New York, Michigan, Texas and Pennsylvania are the top five states for employer retiree coverage, representing 40% of total EGWP enrollment.[2]

Many of the 7.4M EGWP enrollees are retirees from state and local governments, including first responders, teachers and other public workers. In addition, many labor unions have fought for better retiree health benefits—including EGWP drug coverage—through collective bargaining with employers. For all of these retirees, EGWPs provide health and retirement security that has been well-earned through a lifetime of hard work and service to our communities.

Why EGWPs are worth protecting

EGWPs are granted flexibilities from the Centers for Medicare & Medicaid Services (CMS) that allow them to offer benefits that maintain a level of coverage specified by commitments to retirees. As these flexibilities are paid for by the employer/retirement system as a life-long retirement benefit, they enable employers to pay for drug benefits that are much more comprehensive and cost-effective for their retirees.

Lower out-of-pocket (OOP) costs help EGWPs receive greater contributions from drug manufacturers—through the Coverage Gap Discount Program—and reduce costs in the Part D catastrophic benefit phase.

+

Employers pay for drug benefits that are much more comprehensive and cost-effective for their retirees

Enhanced Drug Benefits: While EGWPs must meet the same standard for actuarial value as other Part D plans, employers have more flexibility to enhance the standard Part D benefit cost sharing in different phases of the benefit. This buy-up, which is funded by the employer, retirement system or union, builds upon the standard Part D benefit and is sometimes known as an "Employer Wrap."

In practice, EGWP coverage is far more robust than what is offered by other Part D plans. Though there is a lot of variation across employers, EGWPs typically have lower or no deductibles and charge enrollees fixed copayments for their prescriptions (see Member Cost Sharing in Table 1). In addition, they typically offer broader formularies and allow enrollees better access to medicines. As an example, 92% of Express Scripts EGWP members are in an open formulary. And 98% of the Express Scripts EGWPs have an enhanced formulary and cover non-Part D drugs.

Higher Discounts from Manufacturers: Part D beneficiaries move through the coverage gap and into the catastrophic coverage phase based on their true out-of-pocket (TrOOP) costs. TrOOP costs include both the OOP costs paid by the enrollee and the discounts paid by drug manufacturers in the coverage gap. Since EGWP enrollees have lower OOP costs, they move through the Part D benefit phases more slowly than other beneficiaries—even if the cost of the drug is the same. Lower OOP costs for EGWP enrollees prolongs the time they spend in the coverage gap compared to non-EGWP enrollees. For this reason, drug manufacturers pay more coverage gap discounts to EGWPs than other Part D plans (see Table 1), which EGWPs reinvest to offset the costs of the more generous coverage or higher premiums.

TABLE 1:

Stakeholder costs for hypothetical patient taking a $1,000-a-month brand drug, Standard Plan vs. EGWP, 2021

STANDARD PLAN	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Manufacturer Discount	$0	$0	$0	$0	$0	$609	$700	$700	$700	$411	$0	$0	**$3,820**
Member Cost Sharing	$584	$250	$250	$250	$250	$250	$250	$250	$250	$167	$50	$50	**$2,851**
Plan Liability	$416	$750	$750	$750	$141	$50	$50	$50	$50	$91	$150	$150	**$3,399**
Federal Reinsurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$331	$800	$800	**$1,931**

EGWP	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Manufacturer Discount	$0	$0	$0	$0	$609	$700	$700	$700	$700	$700	$700	$700	**$5,509**
Member Cost Sharing	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	**$600**
Plan Liability	$750	$750	$750	$750	$141	$50	$50	$50	$50	$50	$50	$50	**$3,491**
Employer Wrap	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	**$2,400**
Federal Reinsurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**

Assumes standard benefit design for Standard Plan and no deductible and $50 brand copayment for EGWP.

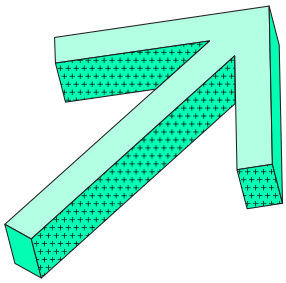
Plan Liability and Employer Wrap are both paid for by the employer.

If EGWP providers cease offering coverage to retirees, it is estimated to increase annual federal reinsurance liabilities by $2.5B to $3B

Improved Employer, Retirement System and Union Finances: Medicare subsidies (through the direct subsidy and reinsurance payments) combined with coverage gap discounts discounts allow employers to maximize their resources through EGWPs versus other retiree drug coverage options such as RDS. If these subsidies and discounts diminish, employers, retirement systems and unions would need to find other funds to meet their obligations to their workers or reduce their benefits. The alternative is placing all EGWP beneficiaries on the individual Part D open market. This would greatly increase Medicare's liability during the reinsurance phase (see Table 1). If EGWP providers cease offering coverage to retirees, it is estimated to increase annual federal reinsurance liabilities by $2.5B to $3B.[3]

Signficant Value for Medicare: EGWP enrollees have lower OOP costs, which result in fewer EGWP beneficiaries reaching the catastrophic phase of the benefit where Medicare pays 80% of drug costs. In a March 2020 report, MedPAC cited that only 5% of EGWP enrollees reached the catastrophic phase compared to almost twice the share of non-EGWP enrollees.[4] Also, the comprehensive drug coverage offered by EGWPs can improve access to prescription drugs, thereby increasing medication adherence. Successful adherence to medications can improve health outcomes and lead to lower medical costs, which may decrease Medicare spending on services covered by Parts A and B.[5]

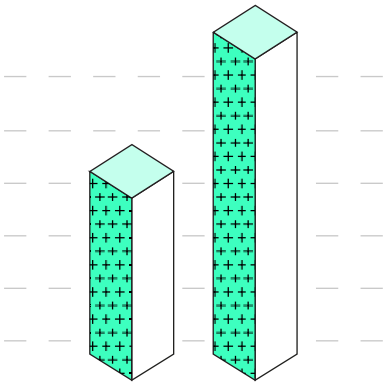
PROPOSED CHANGES THREATEN EGWPs—BUT IT'S NOT TOO LATE



Several independent analyses found the Rebate Rule would raise federal spending and increase seniors' premiums by as much as 25-40%

Policymakers are currently considering several changes to Medicare Part D that would have a substantial impact on the ability of employers to continue to offer high-quality drug coverage through EGWPs. Proposals to redesign the Part D benefit have been put forth by bipartisan, bicameral leaders in Congress aimed at reducing OOP costs for a subset of seniors who reach the catastrophic phase and decrease Medicare's spending on reinsurance. While these are worthy goals, the problems of high OOP costs and large reinsurance payments do not exist in the EGWP market, so policymakers should be careful to avoid creating disruption.

In addition, the final Rebate Rule from the previous Administration, set to take effect in 2023, will result in higher costs for patients, taxpayers and plan sponsors.[6] In fact, several independent analyses, including one by the Congressional Budget Office[7] (CBO) and by CMS' own actuaries,[8] found the Rebate Rule would raise federal spending and increase seniors' premiums by as much as 25-40%, while providing only limited relief on OOP costs for select beneficiaries. Because patients in EGWPs almost always pay fixed copayments that are not based on the price of the drug, the Rebate Rule will increase premiums for employers and unions without reducing drug list prices at all.



Many EGWPs would not benefit from the proposed changes to the Medicare Part D program

Current Part D Redesign Proposals

One Senate proposal, the Prescription Drug Price Reduction Act (PDPRA), and two House proposals, the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3) and the Lower Costs, More Cures Act (H.R. 19), would completely reform the Part D benefit. While there are many differences, key elements are similar across these proposals: 1) patient OOP costs would be capped at the catastrophic threshold, 2) the manufacturer coverage gap discounts would be replaced by a new discount program both above and below the catastrophic phase, and 3) government reinsurance costs would be shifted predominantly onto plans. For all proposals, only OOP costs (not manufacturer discounts) would count towards a patient's OOP cap and manufacturer discounts would be higher above the cap than below it.

Many of these reforms to standard Part D plans are intended to address rising drug costs for both beneficiaries and the federal government. However, very few EGWP beneficiaries will experience those benefits, as the reforms are attempting to correct problems not applicable in the EGWP market. In fact, both proposals cause the drug benefits that workers have fought for to be in jeopardy. Due to their employer subsidies, very few EGWP beneficiaries have high-enough OOP costs to enter the newly proposed catastrophic phase, where their plan could access higher discounts and federal reinsurance. That means that many EGWPs would not benefit from the proposed changes to the manufacturers' discount. In fact, the discount paid by manufacturers for retirees enrolled in EGWPs will be substantially lower than what is paid today. If policymakers hope to increase manufacturers' liability in the Part D program to disincentivize high prices, applying these reforms to impact EGWPs will have the opposite result.

Given this financial reality, employers, unions and state and local governments will be forced to make difficult decisions, either shouldering sharp premium hikes, increasing OOP costs for patients, or not offering drug coverage for their retirees at all and placing them on the individual Part D open market where more costs will shift to the federal government.

Congress can reform Part D and still retain the value of EGWPs

Reforms are essential to keep drug prices affordable and to protect patients from high OOP costs. However, Part D reforms must also protect the EGWP drug benefits that millions of retirees depend on. Recognizing that applying a separate set of rules for EGWPs may not be administratively feasible nor efficient, we propose a solution (on the following page) that policymakers can incorporate into current Part D redesign proposals to protect EGWP beneficiaries and plan sponsors.

This change would result in the least amount of disruption for retirees by making it easier for EGWPs to maintain their current coverage

Treat EGWPs as defined standard plans with respect to catastrophic coverage

Today, EGWP sponsors follow the rules that apply for defined standard benefit plans, regardless of the benefit structure of the Other Health Insurance benefit. To avoid penalizing employers, retirement systems and unions for honoring their commitments to retirees and paying for more valuable coverage, we propose a technical fix to Part D redesign proposals. For EGWPs only, allow the cost-sharing amount dictated under the standard benefit design to count towards the beneficiary's OOP cap. This would be similar to how manufacturer discounts are calculated, based off the defined standard benefits for EGWPs today—easing any challenges CMS may have in implementing this change.

Another way to think about this recommendation is to leverage the total gross spend accumulator, which will be determined as part of the new defined standard spend amount, for entry into the catastrophic stage. This change would result in the least amount of disruption for retirees by making it easier for EGWPs to maintain their current coverage, preventing drug manufacturers from paying lower manufacturer discounts, and maintaining the ability to have EGWPs operate as a "wrap" while still achieving policymakers' goals of Part D benefit redesign proposals.

As shown in Table 2 and Figure 1, counting only the employee contribution based on the defined standard would lower the members' copay while maintaining program stability.

TABLE 2:

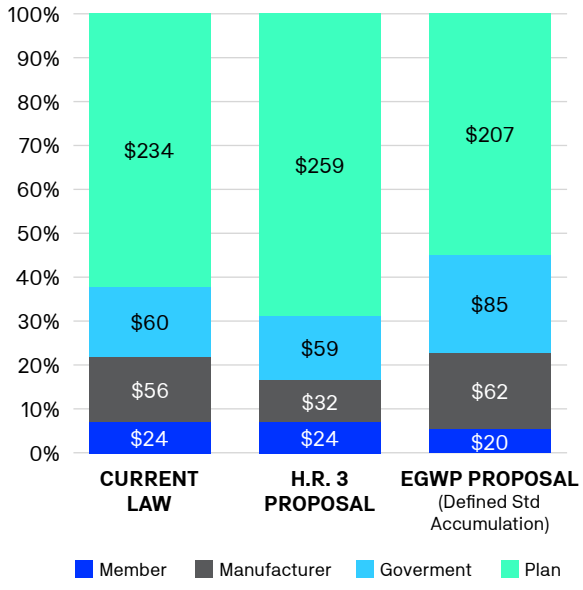
Estimated stakeholder costs for plan* under three policy options, 2022 PMPM

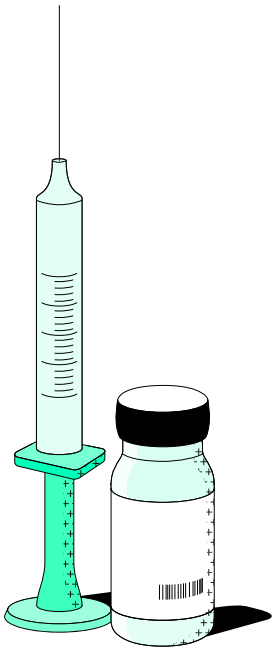
	CURRENT LAW	H.R. 3 PROPOSAL	EGWP PROPOSAL (Defined Std Accumulation)
Drug Cost	**$374**	**$374**	**$374**
Member Cost Sharing	$24	$24	$20
Manufacturer Discount	$56	$32	$62
Federal Reinsurance	$60	$1	$27
Net Claim Cost	**$234**	**$317**	**$265**
CMS Direct Subsidy	$0	$58	$58
Plan Liability	**$234**	**$259**	**$207**

* Three-tier copay plan ($5/$20/$50)

FIGURE 1:

Contribution by stakeholder





Eliminating the use of rebates in Part D creates winners and losers among seniors and would be especially harmful for EGWPs

We strongly encourage the Administration or Congress to repeal the Rebate Rule

In 2020, the Trump Administration finalized the Rebate Rule, which eliminates the safe harbor for rebates from drug manufacturers to Part D plan sponsors, thus requiring that all discounts from manufacturers be offered to the patient at the point-of-sale. Eliminating the use of rebates in Part D creates winners and losers among seniors and would be especially harmful for EGWPs.

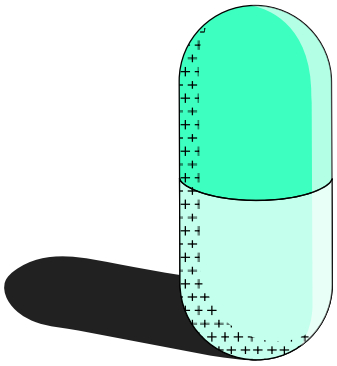
Harmful Effects of the Rebate Rule

+ **Higher premiums for retirees.** As noted earlier, several independent analyses found that the Rebate Rule would increase seniors' premiums by as much as 25-40%. Employers, retirement systems and unions, which subsidize EGWP premiums, would feel the brunt of a premium hike, making retiree drug coverage less affordable to provide. For states and local governments, it would reduce OPEB actuarial savings.

+ **Profits for drug manufacturers.** Pharmaceutical manufacturers benefit the most from the Rebate Rule. Independent analysts show that point-of-sale discounts would be lower than manufacturer rebates, allowing drug manufacturers to realize billions in revenue currently used to subsidize EGWPs. Also, the Rebate Rule would decrease the total amount of CGDP discounts paid by manufacturers in Part D.[9]

+ **Higher costs for the federal government.** CMS and CBO agree the Rebate Rule would cost the government substantially, resulting in almost $200 billion in higher federal spending over the next decade.[10]

+ **Little gain for EGWP beneficiaries.** While some beneficiaries may pay less if their prescriptions carry rebates (such as during the deductible phase) or if their cost-sharing is based on co-insurance rather than copays, the majority of beneficiaries would not.[11] Retirees in EGWPs typically pay fixed copayments for their prescriptions, so these beneficiaries would gain little from the Rebate Rule. For example, 80% of Express Scripts EGWPs have a flat copay for preferred brand drugs.



The proposals currently under consideration would make it harder, not easier, for employers and unions to continue providing comprehensive drug coverage

Bottom Line: Policymakers can reform *and* protect

Despite skyrocketing drug prices, EGWPs in Part D have made drugs affordable for beneficiaries—and coverage affordable for the government, employers and unions. While drug pricing reform is essential, the proposals currently under consideration would make it harder, not easier, for employers and unions to continue providing comprehensive drug coverage for their retirees. Thankfully, by considering the policy options described above, policymakers can do both—enact meaningful reforms and protect employer drug benefits for millions of retirees covered under EGWPs.

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9. Centers for Medicare and Medicaid Services, Office of the Actuary, Memorandum on Proposed Safe Harbor Regulation, August 2018, available at: *https://www.regulations.gov/document/HHSIG-2019-0001-0004.*

10. Congressional Budget Office, Incorporating the Effects of the Proposed Rule on Safe Harbors for Pharmaceutical Rebates in CBO's Budget Projections—Supplemental Material for Updated Budget Projections: 2019 to 2029, May 2019, available at: *https://www.cbo.gov/system/files/2019-05/55151-SupplementalMaterial.pdf.*

11. Milliman, Impact of Potential Changes to the Treatment of Manufacturer Rebates, January 2019, available at: *https://www.regulations.gov/document/HHSIG-2019-0001-0002.*

MORE INSIGHTS

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CLICK TO SHARE

EVERNORTH℠

Health services built on the recognition that health makes progress possible.
We deliver flexible and focused solutions for every business, for every person, for all.

Chronic and complex conditions are exhausting the American health care system. Today, a majority of Americans require ongoing medical attention and, often, lifelong use of prescription drugs. These individuals must work harder every day to manage the symptoms and stress of their chronic conditions. Sixty percent of Americans, and thirty-three percent of **CLIENT** members are living with a chronic condition.[1] These individuals must work harder every single day to manage physical symptoms, emotional stress and uncertainty about their future. It's no wonder that chronic conditions are the leading driver of healthcare costs, putting a $2.9 trillion financial strain on the American healthcare system as we grapple with how to treat, prevent and manage these illnesses.[1] To keep up with the prevalence of these diseases and the often sky-high cost of treatments, our healthcare system is also working harder, but not more efficiently. Because of a historic focus on volume over value, we are spending more money on our healthcare — nearly twice as much as other countries[2]— but we are not achieving better results. In fact, by 2030, 80 million Americans are expected to have three or more chronic conditions. [3] To make the system work better, we must make medicine work harder. Express Scripts works to drive better clinical outcomes for the most complex, costly conditions patients and Plans like the **CLIENT** face. Express Scripts deploys a proven mix of condition-specific patient engagement tools –some of which you may have used thru their website, mobile app and their Specialist Pharmacists.

We understand that patients often struggle to take their medications as prescribed due to a wide range of factors. Cost, side effects, perceived or actual low efficacy, and even forgetfulness all influence adherence. Express Scripts works with the **CLIENT** to offer an approach that considers both the financial and clinical challenges of each unique conditions of our patient population. For example, **XX** % more **CLIENT** members with diabetes started potentially lifesaving statin therapy in 2020 because of the specialized support they received from Express Scripts. This translates to lower downstream medical and prescription costs for all. That is making medicine work harder. When medicine works harder, our healthcare system works better. It is no secret that patient care can be improved and cost must be better managed for the most complex chronic conditions that Americans face. The value the Express Scripts care management programs has been proven to do both.

Examples of Express Scripts engagement that you or your family members may have utilized to better manage your care and improve outcomes include:

- Pulmonary Remote Monitoring: **CLIENT** patients reported a **XXX**% decrease in use of a rescue inhaler after one year of use of the Propeller Monitor, offered at no charge to qualified patients
- Behavior health counseling sessions with Express Scripts Specialist Pharmacist and availability of the digital therapy thru the SilverCloud app
- A bottle cap that fits on top of HIV PrEP prescription bottles that helps patients better adhere to their medication.

These are just a few examples of how Express Scripts is working harder for YOU to improve your health and quality of life. Whenever you have the opportunity to engage- do it!

1. Centers for Disease Control and Prevention
2. JAMA, Health Care Spending in the United States and Other High-Income Countries
3. Deloitte 2018 Study: The Convergence of Health Care Trends

Photo is for representative purposes only and does not depict an actual patient.

Pharmacy Benefit Overview

EXPRESS SCRIPTS®

CRP2107_010419.1 0T2107_0010419

TODAY WE'LL DISCUSS

- Pharmacy benefit available to you
- Helpful information and common definitions
- Resources, including the Express Scripts® mobile app

EXPRESS SCRIPTS®

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tient.

YOUR BENEFIT IS MANAGED BY EXPRESS SCRIPTS

- Medication delivered to your door
- Access to pharmacists 24/7
- Manage prescriptions anytime and anywhere

EXPRESS SCRIPTS®

MEMBER ID CARD

- Includes important information
- Customer service telephone number
- Access electronically

DON’T MISS YOUR SHOT TO PROTECT YOURSELF

VACCINATIONS

- Covered by your prescription plan at a participating retail pharmacy
- Ask your pharmacist which vaccines are right for you and to learn more
- Don’t forget to present your member ID card to the pharmacist

EXPRESS SCRIPTS®

accredo®

A SPECIALTY PHARMACY
CHRONIC & COMPLEX HEALTH CONDITIONS

- Ongoing support from pharmacists & nurses and Therapeutic Resource Centers (TRCs)
- Patient monitoring and care coordination that lead to healthier outcomes
- Mobile and online support tools and patient assistance programs available

EXPRESS SCRIPTS®

Common definitions and helpful information

DRUG LIST

MEDICATIONS ON YOUR DRUG LIST ARE COVERED BY YOUR PRESCRIPTION PLAN

- Routinely reviewed by an independent panel of physicians and pharmacists to ensure you get clinically effective care
- Preferred medications, including generics and brand-name
- Talk with your doctor about moving to preferred generics

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GENERIC PRESCRIPTIONS

FDA-APPROVED GENERIC MEDICATIONS CONTAIN THE SAME ACTIVE INGREDIENT AS BRAND NAME COUNTERPARTS

- Nine out of 10 prescriptions filled in the U.S. are for generic medications
- Review your medications regularly with a doctor or pharmacist and ask, “Is there a generic for that?”
- Use the Express Scripts® mobile app or visit express-scripts.com to find a generic or price a medication

EXPRESS SCRIPTS®

PRIOR AUTHORIZATION

MONITORS PRESCRIPTION MEDICATIONS

- Makes sure your prescription is suitable for the intended use & covered by your prescription plan
- Simply means that more information is needed to see if your plan covers the medication
- To get your prior authorization started, contact your doctor's office

DRUG QUANTITY MANAGEMENT

VERIFIES THE CORRECT QUANTITY OF THE MEDICATION

- Express Scripts will make sure you receive the amount – or quantity – considered safe and effective by the FDA
- Most cost-effective product strength is dispensed
- Helps reduce waste

EXPRESS SCRIPTS®

STEP THERAPY

HELPS REDUCE COSTS

- Safe and proven-effective medication
- First step medications are typically generic and lower-cost brand-name medications
- Second step medications are best suited for the few patients who don't respond to first step medications

EXPRESS SCRIPTS®

Photo is for representative purposes only and does not depict an actual patient.

SMARTER PHARMACY CONSUMER

- Ask your doctor for a generic or a lower-cost equivalent
- Use the most cost-effective pharmacy option
- Take your medications as prescribed
- Don’t be fooled by coupons
- Set reminders to help you stay on track

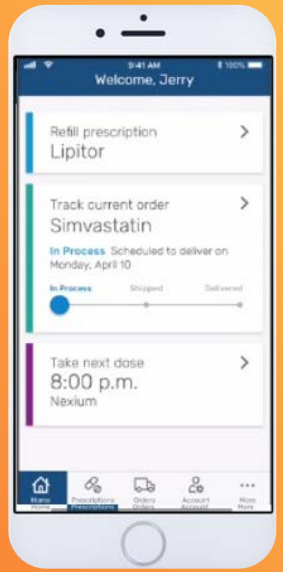
Resources

MEMBER SERVICES

- Customer service number on the back of your member ID card
- Available 24/7
- General information, complex concerns or health conditions

EXPRESS SCRIPTS®

THE EXPRESS SCRIPTS® MOBILE APP



- Download it for free, and use the same username and password to access the mobile app and express-scripts.com
- Home delivery prescription information, price medications and locate a pharmacy near you
- Access your member ID card virtually, view your past prescription activity, get reminder notifications and more!

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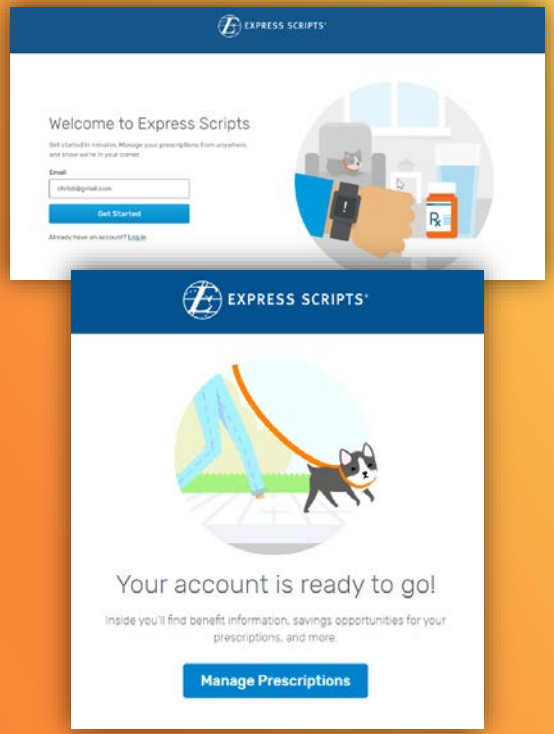

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- Register your preferences, including email address and signing-up for text messaging
- Check order status with tracking details
- Enroll in automatic refills, view pharmacy options and savings, transfer to home delivery, and more!

Details: Beginning at approximately 2:09 PM CT, users were experiencing intermittent errors when accessing functions within Coverage 360. Express Scripts recycled services to alleviate impact and has validated Coverage 360 (C360) is functioning as expected. The end time for this issue was 2:59 PM CT.

- **PHI Implications:** None

Root Cause: Not available

User experience/result: Users may have been unable to service members regarding coverage review details.

Resolution/Preventative Measures: Issue resolved at 2:59 PM CT.

CLIENT LOGO HERE

CLIENT OR TPA
ATTN: NAME OR DEPT.
ADDRESS
CITY, AA 12345
SMPL INT_CRDLS_NG

EXPRESS SCRIPTS®

CHAMPIONS FOR BETTER℠

Important benefit information
Please keep for your records —

ID: CWK000100002
Member Services: 111-111-1111

0999999000001010100

Information about your prescription benefit enclosed.

2022999999 - 000000001 CID PMM-CWK

JOHN Q SAMPLE
123 ANYSTREET
APT. 456
SOMETOWN, US 99999-9999

ALWAYS HERE TO HELP!

Welcome to Express Scripts! As your Champions for Better℠, we're here to give you better, simpler ways to manage your prescriptions and your health. Here are a few highlights ABC Company Employees employees can expect starting May 1, 2022:

Easy
Register online or download the Express Scripts® mobile app to have your info with you at all times and check coverage, medication price and generic availability.

Accessible
Connect with pharmacists in the app, or online and by phone 24/7.

Personalized
Communication options so you can control how you hear from us.

Convenient
Order refills, track shipments, compare prices and access your plan info – all online.[1]

1. First-time visitors must register using their member ID number or Social Security Number. You can manage your medicine online when your coverage takes effect. Before then, you can set up your online account, including your preferred shipping address, preferences, and payment method(s) for home delivery orders.
2. Automated text message will be sent to you. Message and data rates apply. Not a condition of purchase.

Helpful Tips:

- To price a medication, choose "Price a Medication" from the Prescriptions menu, enter your drug name and click Search. After you find your medication, you will be able to view cost and coverage information.
- Whether you are viewing the member website or using the Express Scripts® mobile app, you can easily manage your home delivery prescriptions[1]:
  - Get started by contacting your doctor to request a three-month prescription that he or she can e-prescribe directly to Express Scripts Home Delivery.
  - Or print a form by selecting Forms from the menu under Benefits. Print a home delivery order form and follow the mailing instructions.
  - Or call us and we'll contact your doctor for you.

Please allow 10 to 14 days for your first prescription order to be shipped.

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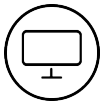
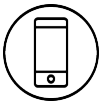
2CLNRT01.LTR

3 easy ways to set up your account and get started:



Visit express-scripts.com

Visit your favorite app store to download the Express Scripts® mobile app



Text JOIN to 69717 for a link to our registration page[2]

Use your new member ID card at participating retail pharmacies near you.

Pharmacy1Name	Pharmacy2Name	Pharmacy3Name
Pharmacy1Addr1	Pharmacy2Addr1	Pharmacy3Addr1
Pharmacy1Addr2	Pharmacy2Addr2	Pharmacy3Addr2
P1City, S1	P2City, S2	P3City, S3

Sign in at express-scripts.com to view pharmacies available near you.

WE'RE YOUR CHAMPIONS FOR BETTER[SM]

Pay less, relax more and skip the trip with home delivery.

Get long-term medication (and savings) delivered right to your door from Express Scripts.

- Up to a three-month supply for just one copay
- Free standard shipping[1]
- Refill online, by phone and with our app
- Sign up for automatic refills and we'll send your medication to you when it's time to refill

Get personalized care from our specialty pharmacy.

You'll use Accredo to fill specialty medications that treat complex conditions like multiple sclerosis, hepatitis C and cancer. Through Accredo, you'll have 24/7 access to specialty-trained pharmacists and nurses who understand your condition. Call us at 800-803-2523 to get started.

Choose from a variety of retail pharmacies.

- Place orders in person, at the pharmacy or over the phone
- Pick up your prescription at a participating network retail pharmacy
- You may need to fill long-term medications with home delivery, but you can always fill your acute prescriptions at retail

Preferred Medications.

Your plan has a list of generic and brand-name drugs that are preferred. The list may change and some preferred medications may become nonpreferred, some may become preferred and some may no longer be covered. Here's the difference:

- Preferred (or formulary) drugs cost less than nonpreferred. This list of medications is determined based on the advice of pharmacists and a group of independent doctors. (It's applicable to many clients serviced by Express Scripts.)
- Nonpreferred (or nonformulary) drugs may cost you more.
- Noncovered (or excluded) drugs aren't covered under the plan. You can log in at express-scripts.com to see any Formulary Exclusions that apply to your plan.

[1]Standard shipping costs are included as part of your prescription plan.

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