

2009 Evidence of Coverage (EOC)

our Summary of Benefits. If you do not have a current copy of the Summary of Benefits you can view it on our website or contact Customer Service to request one.

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

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., deductible, initial coverage period, the period after you reach your initial coverage limit and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below. Refer to your plan formulary to see what drugs we cover and what tier they are on. (More information on the formulary is included later in this section.)

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs.” If you do not already qualify for extra help, see “Do you qualify for extra help?” in Section 1 for more information.

Initial Coverage Period

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

You will pay the following for your covered prescription drugs:

Drug Tier	Network Retail Cost-Sharing one month supply – 30 day supply	Network Retail Cost-Sharing extended day supply - 90 day supply	Network Long-Term Care Cost-Sharing one month supply days-30 day supply	Network Mail-Order Cost-Sharing one month supply days- 30 day supply	Network Mail-Order Cost-Sharing extended day supply days- 90 day supply	Out-of-Network Cost-Sharing 30-day supply
Tier 1 Preferred Generics	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Tier 2 Generics	\$5.00	\$15.00	\$5.00	\$5.00	\$15.00	\$5.00
Tier 3 Plus Plus Brands	\$10.00	\$30.00	\$10.00	\$10.00	\$30.00	\$10.00
Tier 4 Preferred Brands	\$30.00	\$90.00	\$30.00	\$30.00	\$90.00	\$30.00
Tier 5 Brands	\$60.00	\$180.00	\$60.00	\$60.00	\$180.00	\$60.00
Tier 6 Specialty Drugs	33%	NA	33%	33%	NA	33%

2009 Evidence of Coverage (EOC)

Once your total drug costs reach \$2700.00, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

Coverage Gap

After your total drug costs reach \$2700.00, we will continue to provide some prescription drug coverage until your total out-of-pocket costs reach \$4350.00. The plan covers all preferred generics and some brands through the gap. Refer to the formulary to find out which drugs are covered through the gap. Once your total out-of-pocket costs reach \$4350.00, you will qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4350.00 out-of-pocket for the year. When the total amount you have paid toward coinsurance or co-payments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches \$4350.00, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of 5% coinsurance or \$2.40 for generics or drugs that are treated like generics and \$6.00 for all other drugs. We will pay the rest.

Vaccine Coverage (including administration)

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

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, following our out-of-network paper claims policy (see Section 2), and then you will be reimbursed up to our normal coinsurance or copayment for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

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

2009 Evidence of Coverage (EOC)

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal coinsurance or co-payment for the vaccine.
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal coinsurance or co-payment for the vaccine (including administration)
The Pharmacy	Your Doctor	You pay your normal coinsurance or co-payment for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine

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

How is your out-of-pocket cost calculated?

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

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

- Your annual deductible ;
- Your coinsurance or co-payments up to the initial coverage limit
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

When you have spent a total of \$4350.00 for these items, you will reach the catastrophic coverage level.

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

The amount you pay for your monthly premium (if your plan has a premium) doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories

2009 Evidence of Coverage (EOC)

- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare”

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

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

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

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




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

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

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

Sample plan membership card

Here is an example of what your plan membership card looks like. See Section 1 for more information on using your plan membership card.

		MEDICARE HMO Co-Pays
FRONT	ID#: Plan #: SAMPLE	PCP/Spec/Lab \$X/\$X/\$X Rx \$X/\$XX ER \$XX Urgent Care \$XX
	Effective Date: PCP: PCP Phone Number:	 ISSUER: 80840 RXBIN: 004758 RXPCN: DNPS RXGRP: H5407XXX
	Card Issued:	
BACK	FOR EMERGENCIES: Go directly to the nearest emergency room or call 911. You should call your Primary Care Physician (PCP) as soon as possible for further assistance and coordination of follow-up care. 24 Hour Citrus Nurse Line: 1-888-952-4878 <i>Except for emergency care, doctors & hospitals must call CHC to authorize admissions and certain other services. This card does not prove membership nor guarantee coverage.</i>	
	CHC Customer Service: 1-877-624-8787 SAMPLE	
	TDD/TTY: 1-888-248-7875 Authorizations: 1-866-769-1159 Pharmacy: 1-800-546-5677 Provider Claims Inquiry: 1-866-769-1160 Behavioral Health: 1-800-221-5487 Dental Services: 1-800-641-4345 Laboratory: LABCORP www.citrushc.com	CHC Claims Address: PO Box 20547 Tampa, FL 33622-0547

General Exclusions

Introduction

The purpose of this part of Section 10 is to tell you about medical care and services, items, and drugs that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items, and drugs that aren't covered under any conditions, and some services that are covered only under specific conditions. The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services.

If you get services, items or drugs that are not covered, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items, or drugs that we should have paid or covered (appeals are discussed in Section 5).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this EOC, **the following items and services aren't covered under the Original Medicare Plan or by our plan:**

1. Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the

2009 Evidence of Coverage (EOC)

bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

9. Homemaker services.
10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines.
15. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines. Except as indicated in the benefits chart.
16. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
17. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
18. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
19. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
20. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
21. Acupuncture.
22. Naturopath services.
23. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount
24. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Excluded Drugs

This part of Section 10 talks about drugs that are “excluded,” meaning they aren't normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 5).

2009 Evidence of Coverage (EOC)

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

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

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

The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary or call Customer Service for more information.

If you receive extra help, 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.

Index

A

Appeal, 41, 43, 45, 46, 47, 48, 49, 52, 53, 55, 60

B

Benefit period, 60
Brand, 60

C

Catastrophic Coverage, 6, 61, 94
complaints, 33, 36, 37, 51, 66, 71
coverage determination, 16, 19, 20, 22, 27, 28, 29, 31, 38, 61, 62
covered services, 4, 3, 4, 10, 11, 12, 13, 14, 17, 18, 31, 34, 60, 64, 65, 75, 76, 80, 87, 90
Customer Service, 1, 3, 6, 7, 8, 4, 5, 7, 9, 10, 12, 14, 16, 19, 22, 24, 25, 26, 29, 30, 31, 32, 33, 34, 35, 36, 39, 51, 53, 54, 57, 58, 64, 68, 72, 76, 93, 95, 98, 101

D

Disenroll, 61

E

emergency, 10, 14, 15, 16, 21, 26, 34, 62, 67, 76, 82, 92, 93, 98, 100
Evidence of Coverage, 5, 7, 8, 1, 3, 8, 62, 65, 74, 93

F

formulary, 5, 6, 3, 6, 18, 19, 20, 21, 22, 24, 27, 28, 33, 38, 39, 41, 58, 62, 65, 66, 93, 94, 96, 101

G

generic, 19, 22, 60, 62
Grievance, 1, 35, 36, 62

I

initial coverage limit, 6, 93, 94, 96
Inpatient, 3, 11, 18, 63, 76, 77, 78, 88, 90

M

medically necessary, 16, 18, 27, 41, 50, 51, 52, 53, 54, 55, 56, 61, 76, 77, 81, 85, 88, 99, 100
Medicare, 1, 3, 4, 5, 6, 7, 8, 3, 4, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 23, 24, 27, 28, 29, 30, 32, 33, 34, 36, 47, 49, 51, 52, 53, 54, 55, 57, 58, 60, 61, 62, 63, 64, 65, 66,

68, 70, 71, 72, 74, 75, 76, 79, 81, 84, 85, 88, 90, 94, 96, 99, 100, 101, 102
Medicare Advantage, 3, 29, 63, 64, 71, 72, 79
Medigap, 23, 64, 71
Member Services, 13

N

Network pharmacy, 64

O

Organization Determination, 65
out of network, 10, 15, 21, 26, 90

P

Part D, 3, 5, 7, 1, 5, 6, 21, 23, 24, 25, 28, 29, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 61, 64, 65, 69, 70, 72, 75, 88, 93, 94, 96, 97, 101
plan provider, 11, 13, 14, 60, 75, 77, 90
Primary Care Physician, 4, 11, 13, 65, 98
Primary Care Physician (PCP), 13, 98
prior authorization, 10, 12, 13, 20, 22, 26, 33, 38, 41, 66, 76

Q

QIO, 36, 51, 52, 53, 54, 55, 66, 71

R

rehabilitation, 37, 53, 60, 61, 66, 71, 82, 90, 99

S

service area, 3, 4, 10, 14, 15, 16, 25, 26, 27, 34, 57, 58, 63, 66, 88, 93
Step Therapy, 22, 66

U

Urgently needed, 14, 15, 16, 67, 82
Urgently needed care, 14

