Summary of Significant Changes to 2007 Model PDP Evidence of Coverage

Section	Update
Document as a whole	Correction of formatting, grammar, and typographical errors, including page numbering and update of table of contents.
Benefits At a Glance	In Plan Premium section, added section titles for Sections 2 and Section Three
	In "Requirements or restrictions on when you can get covered drugs" section, added paragraph: If your physician determines that you are not able to meet a prior authorization, quantity limit, step therapy restriction, generic substitution, or other utilization management requirement for medical necessity reasons, you or your physician may **request an exception**. See Section 6 to learn more about how to request an exception.
	In "Benefit" section ,in first paragraph, added title for Section 4, also in note, corrected title of LIS Rider to "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs".
	After the table in the section titled "Initial Coverage Period", added: "* Amounts in this chart may vary according to your individual out-of-network cost sharing responsibility."
	In the section titled "Catastrophic Coverage", corrected bracketed information as follows: [the greater of $<2.15> for generics or drugs that are treated like generics and $<5.35> for all other drugs, or 5% coinsurance. We will pay the rest.]
	In the section titled "Coverage for non-Part D Drugs", first sentence in first paragraph was changed as follows: There are some drugs that Congress specifically excluded from standard Medicare prescription drug coverage (Medicare Part D)
	In the section titled "Transition Policy", added title name for Section 6 in the first paragraph, and changed reference to "off-formulary" drugs to "non-formulary" drugs

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	In the section titled "Transition Policy", the third paragraph to read as follow: If the new member is a resident of a long-term care facility, we will cover a temporary <*must be at least 31*>-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first <*must be at least 90*> days for a new member of our plan who is a resident of a long-term care facility. If a new member who is a resident of a long-term care facility needs a drug that is not on our formulary or subject to other restrictions, such as step therapy or dosage limits, but the new member is past the first <*must be at least 90*> days of new membership in our plan, we will cover a <*must be at least 31*>-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.
	In the section titled "Transition Policy", added fourth paragraph: Please note that our transition policy applies only to those drugs that are "Part D drugs" and that are purchased at a network pharmacy. The transition policy could not be used to purchase a non-Part D drug or a drug out-of-network, unless the individual qualifies for out-of-network access.
	Under "How to Contact Our Plan's Customer/Member Service", PBM phone number is now optional
Introduction	In section titled "This Evidence of Coverage explains how to get your Medicare prescription drug coverage through our plan" after first paragraph, introduction to bulleted section reads: "This Evidence of Coverage provides information that will explain to you:"
Section 1 – Plan Basics	In the section "Overview of Medicare prescription drug coverage", added the following note: **Note:** For Plan members with Diabetes, Medicare Part B supplies that will not be under the drug benefit include lancets, test scripts, glucometers, etc. Diabetic supplies that are covered under Medicare Part D include those items related to the injection of insulin, e.g., insulin syringe, gauze, and alcohol swabs. Inhalers associated with the inhaled form of insulin are also

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	covered under Medicare Part D.
	In the section "What are network pharmacies", first bullet added at the end of bulleted section: However, if you switch to a different network pharmacy, you must either have a new prescription written by a physician or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.
	In the section "Filling prescriptions outside the network, after first paragraph", added the following note: [**Note**: If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you went to an in-network pharmacy.]
	In the section titled "How do I submit a paper claim, added the following after the first paragraph: If you submit a paper claim to us, the claim is treated as a request for a coverage determination. If you are asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 6 to learn more about requesting coverage determinations.
	In the section titled, "Home infusion pharmacies", first bullet was changed as follows: Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug
	In the section titled, "Some vaccines and drugs may be administered in your doctor's office", first sentence was modified to read: We may cover vaccines that are preventive in nature (but not the cost associated with administering the vaccine) and are not already covered by Medicare Part B
Section 2 – Extra Help with Drug Plan Costs for People with Limited Income and Resources	In the section titled, "What extra help is available?", first paragraph was changed to read: Medicare provides "extra help" to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's [monthly premium,]

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	[yearly deductible,] [and] prescription co-payments.
	Under "Do you qualify for extra help?" number 2 re-worded to read as follows: You apply and qualify. You may qualify if your yearly income is less than $14,700 (single) or $19,800 (married and living with your spouse), and your resources are less than $11,500 (single) or $23,000 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next. The above income and resource amounts are for 2006 and will change in 2007. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.
	First sentence under "How do my costs change when I qualify for extra help?", changed to read: The extra help you get from Medicare will help you pay for your [Medicare drug plan's monthly premium,] [yearly deductible,] and prescription co-payments.
Section 3 – Monthly Premiums	Under section title "Paying the plan premium for your coverage as a member of our plan", in the section paragraph following Option One, first sentence revised to read: Instead of paying by check, you can have your premium [automatically withdrawn from your bank account,] [or] [charged directly to your] [credit card] [or] [debit card].
	Section titled "What is the late enrollment penalty" section has been reworded for clarity.
Section 4 – Prescription Drug Coverage	Under the section titled "What are drug tiers?", second paragraph now reads: You can ask us to make an exception (which is a type of coverage determination) to your drug's tier placement in certain circumstances. See Section 6 to learn

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	more about how to request a "tiering exception."]
	Under the section “Can the formulary change?”, the second to the last sentence in the first paragraph no reads: However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60-days notice before removing the drug from the formulary or give you a 60 day supply of the drug when you request a refill.
	Third bullet, under “What if your drug is not on the formulary”, last sentence now reads: If the exception is not approved, you may appeal the plan's denial. See Section 6 for more information on how to request an exception or appeal.
	Second paragraph after bulleted section under “What if your drug us not on the formulary”, last sentence in paragraph now reads: Please see the Benefits at a Glance section in the beginning of this document to learn more about our transition policy.
	Under the section titled, “Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?”, last paragraph, now reads: We will be responsible for keeping track of your out-of-pocket cost amount 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, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.
Section 6 - Appeals & Grievances: What to do if you have complaints	Information in this section related to appeals level threshold amounts were changed
Section 7 – Leaving this Plan and Your Choice for Continuing	Under section “When can you disenroll/switch prescription drug plans”, last paragraph now reads: If you have a Medigap (Medicare Supplement) Policy with

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Prescription Drug Coverage after You Leave	prescription drug coverage, you should have received a letter in the fall of 2005 and another one prior to the Annual Coordinated Enrollment Period in the fall of 2006 from your Medigap issuer explaining your options and explaining whether your coverage under the policy is creditable or not. If you did not get either of these letters or cannot find them, contact the issuer of your Medigap policy.
Section 8 – Your Rights and Responsibilities as a Member of this Plan	The following note was added under the section "Your right to privacy of your medical records and personal health information" **NOTE: As a member of <Plan Name> personal information, including prescription drug event data, will be released to Medicare, who may release it to researchers pursuant to all applicable privacy laws, for research purposes.**
Section 10 – Definitions of Some Words Used in this Evidence of Coverage	Definitions for the following terms were modified: Credible coverage, Initial Coverage Period, and Out-of-Network Pharmacy