



UPREHS PRIME MEDICARE PLAN (EMPLOYER PDP) BENEFIT GUIDE

Your Medicare Prescription Drug coverage as a Member of the
UPREHS Prime Medicare Plan

2011

Just a \$9 copayment gets you a 90-day supply of any Tier 1 Generic drug from the Depot Drug Mail Pharmacy while you are in your Initial Coverage benefit stage. That is just \$3 for each 30-day supply. Don't let the so-called \$4 drugs fool you!

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

UPREHS Customer Services

For help or information, please call Customer Services Monday through Friday from 7:30 am to 3:30 pm Mountain Time. Calls to this number are free:

1-800-547-0421

TTY/TDD Call the national number 711

Website: WWW.UPHEALTH.COM



Medicare^{Rx}
Prescription Drug Coverage

E7316EOC2011

Medicare^{Rx}
Prescription Drug Coverage

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2011 UPREHS Prime Medicare Plan Benefits at a Glance

NEW: A \$9 copayment gets you a 90-day supply of any Tier 1 Generic drug from the Depot Drug Mail Pharmacy while you are in your Initial Coverage benefit stage. For questions please contact UPREHS Customer Services at 1-800-547-0421 Monday-Friday, 7:30 AM to 3:30 PM Mountain Time. TTY/TDD users call the national number 711. Use the Depot Drug Mail Pharmacy whenever possible!

NOTE: Federally qualified low-income members have lower, or no copayments and premiums may be less. If you are receiving extra help, you will receive additional information. Drug costs can fluctuate daily so they may not be the same amount on each prescription you fill.. Benefits, formulary, pharmacy network, premiums and copayments may change on January 1, 2011.

Part D Benefits	UPREHS Prime Medicare Part D Plan Benefits Description <i>An Enhanced Plan</i>
Premium for Medicare Part D, HCPP & Medicare Secondary Plans is Combined	\$220 is your combined monthly premium covering ALL of your UPREHS Medicare Plans. You must still pay your Medicare Part B Premium.
\$310 Deductible – UPREHS pays this for you!	You pay NO DEDUCTIBLE! \$310 is paid for you by UPREHS! No first-dollar costs to you except for drug copayments.
Initial Coverage Amount, or Initial Coverage Limit Benefit Stage	You receive \$2, 840 in drug benefits during your Initial Coverage stage. Medicare determines this amount. Your Initial Coverage must match Medicare’s National Standard so that UPREHS can apply the new Coverage Gap discounts for 2011 (see below).
Coverage Gap, or Out-of-Pocket Benefit Stage	Once you use your Initial Coverage Amount, you will go into the Coverage Gap. Medicare law requires you to pay \$4,550 out-of-pocket for your drugs and then you will be in Catastrophic Coverage. All of your prescription copayments and drugs you pay for in the Coverage Gap apply to this amount. Continue to use Depot Drug Mail Pharmacy to save money on your drugs while in the Coverage Gap.
7% Generic Drug Discount in the Coverage Gap New for 2011	You receive a 7% discount on the cost of a Generic Drug when you are in the Coverage Gap Out-of-Pocket benefit stage. The discount is given at the time you fill your prescription.
50% Brand Name Drug Discount by Most Manufacturers in the Coverage Gap New for 2011	Brand Name drug Manufacturers are extending a 50% discount on the cost of most Part D drugs when you are in the Coverage Gap Out-of-Pocket benefit stage. This discount is given at the time you fill your prescription.
Catastrophic Coverage Benefit Stage	After you spend \$4,550 out-of-pocket, you will enter the Catastrophic Coverage benefit stage and all Medicare Part D drug copayments are \$2.50 for generic, \$6.30 for brand name drugs, or 5% of the cost of the drug, whichever is greater.
Quantities of Drugs Supplied	New for 2011: Just a \$9 copayment gets you a 90-day supply of any Tier 1 Generic drug from the Depot Drug Mail Pharmacy while you are in your Initial Coverage benefit stage! Supplies of 30-days or less are available from non-preferred pharmacies.
Part D Drugs Requiring Pre-authorization, Cost-Utilization Limits, and Step Therapy	Your Formulary includes all Part D drugs with very few of these limitations. UPREHS applies NO Step Therapy, NO Cost-Utilization Limit, and NO Pre-authorization unless required by Medicare. You don’t have to appeal to get access to a Part D drug!

Formulary	Your Formulary includes all Part D drugs! You are not limited to only certain Part D drugs as you would be with many plans. If you need a Part D drug, UPREHS covers it!
Mental Health Part D Drugs	All Part D drugs are covered in your Formulary! If Medicare covers the drug, it is available to you.
Part D and Part B Diabetic Supplies	The Depot Drug Pharmacies provide up to 90-day supplies of most Part B and D diabetic supplies to save you money.
Home Infusion Therapy Part D Drugs	Contact UPREHS Customer Services for coordination.
Long Term Care Part D Drugs	The Depot Drug Mail Pharmacy provides Long Term Care maintenance drugs to save you money. Get your medications at our special low prices no matter where your facility is located.

2011 UPREHS Prime Medicare Plan Prescription Copayments

2011 30-Day Copayment Amounts for Part D Drugs	Tier 1 Generic Drugs 30-Day	Tier 2 Brand Preferred 30-Day	Tier 3 Brand Non- Preferred 30-Day	Tier 4 Specialty Drugs 30-Day
Depot Drug Mail Pharmacy Preferred Pharmacy \$\$\$ Your Best Money Saver 30, 60 or 90-Day Supplies Available	\$3	\$15	Higher of \$40 or 33% of drug cost	Higher of \$50 or 33% of drug cost
Ascend Specialty Drug Mail Pharmacy - Preferred Pharmacy for chronic diseases requiring self-injectable medications, and those for oncology (cancer) or transplant (not insulin) \$\$\$ Your Best Money Saver 30-Day Supply Available	\$7	\$20	Higher of \$40 or 33% of drug cost	Higher of \$50 or 33% of drug cost
Depot Drug Walk-In Pharmacies Preferred Pharmacies \$\$\$ Your Best Money Saver	\$7	\$20	Higher of \$40 or 33% of drug cost	Higher of \$50 or 33% of drug cost
National Retail Pharmacy Network Non-Preferred Pharmacies 30-Day or less Supply Only	\$15	\$30	Higher of \$50 or 33% of drug cost	Higher of \$100 or 33% of drug cost
Out-of-Network Pharmacy - Emergency Only We refund you the UPREHS cost for the Part D drug minus your tier copayment amount. You pay any charges above UPREHS cost. Non-Part D drugs are not covered.	\$15	\$30	Higher of \$50 or 33% of drug cost	Higher of \$100 or 33% of drug cost
If the actual cost of a drug is less than the Tier copayment amount for that drug, you will pay the actual cost plus dispensing fee, not the copayment! Some "\$4" drugs would cost you less under this rule so make sure that you use your UPREHS ID Card!				

Medicare Coverage Gap Discount Program

Beginning in 2011, the Medicare Coverage Gap Discount Program will provide manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already

receiving “Extra Help.” A 50% discount on the negotiated price (excluding the dispensing fee) will be available for those brand name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount at the Depot Drug Pharmacies and nonpreferred retail pharmacies when your prescriptions are filled. This information will also be displayed when you request an Explanation of Benefits.

It is even more important for you to use Depot Drug Mail Pharmacy because the 50% amount discounted by the manufacturer counts toward your out-of-pockets costs as if you had paid this amount and moves you through the coverage gap. If you use an out of network pharmacy, we cannot guarantee that you will receive the 50% discount, or credit for your out of pocket costs.

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 Services (phone numbers are on the front cover).

UPREHS Forms

The following UPREHS-required forms for various purposes are reproduced here for your convenience. You may photocopy them rather than print them from our website or waiting to receive one by mail from our Customer Services.

Appointment of Representative Form

Accident/Injury Report Form

Coordination of Benefits Form

Physician Prescription Fax Form

Authorization for Release of Protected Health Information

Physician Documentation for an Exception Request or a Compounded Drug

Prescription Drug Claim Form

Request for a Medicare Part D Prescription Drug Coverage Determination

Revocation of Authorization for Release of Protected Health Information

Appointment of Representative Form

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

Form Approved
OMB no. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY

MEDICARE NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY

DATE

STREET ADDRESS

PHONE NUMBER (AREA CODE)

CITY

STATE

ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE

DATE

STREET ADDRESS

PHONE NUMBER (AREA CODE)

CITY

STATE

ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation.

(Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE

DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE

DATE

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

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 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1696 (07/05) EF (07/05)

Accident/Injury Report Form

UPREHS Prime Medicare Plans
PO Box 161020
Salt Lake City, UT 84116-1020
Customer Services: 1-800-547-0421
Fax number: 801-595-4399

The information provided by you in this report is confidential and will not be released to anyone without a signed authorization from you, with the exception of Federal or State law requirements. We are required to obtain this information from you by Federal Medicare law to coordinate your benefits.

Instructions

Complete the requested information below, sign, and date the form, and return it to UPREHS at the address above. This completed form must be signed and returned to UPREHS before claims can be considered for payment.

Member Name _____ Phone (____) _____

UPREHS ID Card # _____ Medicare # _____

Street Address _____

City, State, Zip _____

I was not injured. Describe below the medical condition for which you were treated, including date of onset or initial treatment. _____

I was injured at work. Date of the injury _____ Where are you working? _____
Describe below the accident and the part(s) of your body that were injured. _____

I was injured but not at work. Date of the injury _____ Place of the injury _____
Describe below the accident, the place where you were injured, and the part(s) of your body that were injured. _____

I was injured in an auto accident. Date of the accident _____ Was a police report filed? _____
If yes, please provide auto insurance information

(Name of auto insurance company, policy number, and claim number, if applicable.)

If another party or person was responsible for the accident, provide their name, address, and telephone number. If you have retained an attorney, please note attorney information on the back of this form. Describe below the accident and the part(s) of your body that were injured.

Describe the injury or medical condition below. If additional space is needed, use the back of this form.

Member Signature _____ Date _____

To the best of my knowledge, the information provided is correct.

Coordination of Benefits Form

UPREHS Prime Medicare Plans
PO Box 161020
Salt Lake City, UT 84116-1020
Customer Services: 1-800-547-0421
Fax number: 801-595-4399

ACTION REQUIRED! RETURN COMPLETED FORM TO UPREHS IMMEDIATELY!

Medicare law requires you to provide coordination of benefits information to us each year. You must complete this form and return it to Union Pacific Railroad Employee Health Systems annually or when there is a change. Medicare may have cause to disenroll you from UPREHS if we don't have current information. Complete the questionnaire below and return it to UPREHS by mail at UPREHS, PO Box 161020, Salt Lake City, UT 84116, or fax to 801-595-4399. If your Medicare spouse is covered by UPREHS, please complete the second set of identical questions for your spouse. For help call UPREHS Customer Services at 1-800-547-0421 Monday through Friday, from 7:30 am until 3:30 pm, MST.

Please Answer the Following Questions

As a member of the UPREHS Prime Medicare Plan, you can keep other current prescription coverage that you may already have including other private insurance, Workers Compensation, VA benefits, State assistance programs, and any other coverage you may have for your prescriptions. You can only have one Medicare Part D Plan. Medicare coordinates your benefits, so please list any current coverage you have for prescription drugs that you plan to keep in addition to your Part D UPREHS Prime Medicare Plan.

Member Name (please print) _____ Phone (____) _____

UPREHS ID Card # _____ Medicare # _____

I plan to keep other prescription coverage in addition to UPREHS. Yes No

If you checked "yes", what is the name of your other coverage? _____

What is your identification number (ID number) for this coverage? _____

Please complete this section for your Medicare spouse (if covered by UPREHS)

Please list any current coverage you have for prescription drugs such as other private insurance, Workers Compensation, VA benefits, State assistance programs that you plan on keeping in addition to your UPREHS Prime Medicare Plan.

Spouse Name (please print) _____ Phone (____) _____

UPREHS ID Card # _____ Medicare # _____

I plan to keep other prescription coverage in addition to UPREHS. Yes No

If you check "yes", what is the name of your other coverage? _____

What is your identification number (ID number) for this coverage? _____

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Physician Documentation for an Exception Request or a Compounded Drug

UPREHS Prime Medicare Plan (Employer PDP)

PO Box 161020

Salt Lake City, UT 84116-1020

Customer Services: 1-800-547-0421

Fax number: 801-595-4440

Dear Physician: Medicare requires us to obtain and keep written documentation in our files from you to establish medical necessity for granting an exception or to give prior authorization. Use this form when prescribing a drug that exceeds the quantity limit, a non-preferred formulary drug, a compounded drug, or any other UPREHS Part D exception request. Please provide us with the following medical documentation. Failure to do so could cause a denial of the exception request. Please attach this form to your documentation and fax or mail to the above address or fax number.

Physician Name _____ Date _____

Phone (____) _____ Fax (____) _____ Office Contact _____

Physician Address _____

Physician City, State, Zip _____

Physician DEA # _____ Physician NPI # _____

Member Name _____

UPREHS ID Card # _____

Prescribed Drug Name _____

NDC # _____ Strength _____ Quantity _____ Days Supply _____

Prescribed Drug Name _____

NDC # _____ Strength _____ Quantity _____ Days Supply _____

Prescribed Drug Name _____

NDC # _____ Strength _____ Quantity _____ Days Supply _____

Medical Diagnosis (ICD-9) _____

Please provide us with the following medical documentation. Failure to do so could cause a denial for benefit payment of the request.

- Provide any past history of adverse effects from a commercially available alternative formulary drug, diagnostic tests showing their adverse affects, and/or any additional available evidence that establishes medical necessity for this member's use of the requested drug.
- Include the member's diagnoses and medical reason(s) why an existing commercially available preferred formulary drug would not be as effective for the treatment of our member's medical condition, and/or why discontinued use of the requested drug would have an adverse effect on the health of our member.
- Provide your treatment and follow-up plan for use of the requested drug and duration of the prescribed time period for our member's medical condition.

Prescription Drug Claim Form

UPREHS Prime Medicare Plan
PO Box 161020
Salt Lake City, UT 84116-1020
 Customer Services: 1-800-547-0421
 Fax Number: 801-595-4399

PATIENT & INSURED (SUBSCRIBER) INFORMATION

Patient Name (first, middle, last) _____

Date of Birth _____

Patient Street Address (MM/DD/YYYY) _____

City, State, Zip _____

Insured's Name (first, middle, last) _____

Relationship to Patient Self Spouse Child Other _____

Insured's UPREHS ID Card # _____ Insured's Medicare # _____

Condition Related To Accident Emergency I/P Services

Other Insurance Yes No Other Prescription Coverage Yes No Policy _____

Policy Holder Name _____ Plan Name _____

Patient's or Authorized Person's Signature

I authorize the release of any medical/prescription information necessary to process the claim and request payment of Medicare benefits either to myself or to the party who accepts assignment below.

Patient Signature _____ Date _____

CLAIMS/PRESCRIPTION INFORMATION

* For Compounded drugs: All compounded prescriptions must be submitted on this prescription claim form and provide all NDC's NOT just the NDC of the major ingredient. List the date of service, drug name(s), NDC, strength, quantity, dosage form, and the cost of each ingredient for ALL drugs in the compound. Failure to list any ingredients or quantities will result in a denial for lack of requested information.

Date of Service	Drug Name	NDC No.	Strength	Quantity	Dosage Form	Charge
Signature of Physician or Supplier:		Accept Assignment: Yes () No ()	Total Charge	Amount Paid		Balance Due
Date						
DEA #		Physician or Supplier Address				
Tax Identification #						
NPI #						
NABP #						

Request for a Medicare Part D Prescription Drug Coverage Determination

UPREHS Prime Medicare Plan
PO Box 161020
Salt Lake City, UT 84116-1020
Customer Services: 1-800-547-0421
Fax: 801-595-4399

UPREHS may require additional information. Refer to your UPREHS Prime Medicare Plan Benefit Guide for more information. Return this request to the address above.

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, erectile dysfunction, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations) which are non-covered under Medicare Part D.

Member/Requestor's Information

Member Name _____ Date of Birth _____
(MM/DD/YYYY)

UPREHS ID Card # _____ Medicare # _____

Requestor's Name (if not member) _____ Phone (____) _____

Requestor's Relationship to Member _____

Attach documentation that shows authority to represent enrollee if other than the prescribing physician. See Appointment of Representative Form (CMS form 1696).

Member/Requestor Address _____

City, State, Zip _____

Prescribed Drug Name _____

If known, include: Strength _____ Quantity _____ Days Supply _____

Prescribing Physician's Information

Physician Name _____ Medical Specialty _____

Phone (____) _____ Fax (____) _____ Office Contact _____

Physician Address _____

Physician City, State, Zip _____

Form continues on following page.

Request for a Medicare Part D Prescription Drug Coverage Determination (continued)

Check the type of determination below that you are requesting:

- I need a drug that I believe is covered by Medicare Part D, but is not on the UPREHS Preferred Formulary (formulary exception). *
- I request prior authorization for the Medicare Part D drug my doctor has prescribed.
- I request an exception to the UPREHS plan limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor has prescribed (formulary exception). *
- UPREHS charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception). *
- I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE:** If you are asking for a formulary or tiering exception your PRESCRIBING physician must provide a statement to support your request. The type of information UPREHS requires from your physician is found on the form titled *Physician Documentation Form for an Exception Request or a Compounded Drug*. You cannot ask for a tiering exception for a drug in the UPREHS formulary Tier 1, 2 or 4, or on a drug that you have already received or been allowed under a formulary exception. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs (Tier 1).

Additional information we should consider (attach any supporting documents) OR other request:

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided to you within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for your, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

- I need an expedited (fast) coverage determination (attach your prescribing physician's supporting statement if applicable).

Member/Requestor Signature

Date

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Revocation of Authorization for Release of Protected Health Information

UPREHS Prime Medicare Plans
PO Box 161020
Salt Lake City, UT 84116-1020
Customer Services: 1-800-547-0421
Fax Number: 801-595-4399

I hereby revoke my authorization to Union Pacific Railroad Employees Health Systems to disclose protected health information from the records of:

Member Name _____ Phone (____) _____
UPREHS ID Card # _____ Date of Birth _____
Street Address _____ (MM/DD/YYYY)
City, State, Zip _____

Specific description of information that may NOT now be released (including beginning date(s):

_____ Dues/payment information _____ Medical records (UPREHS Clinics only)
_____ Prescription and/or co-payment information _____ Copies of claims
_____ Explanation of benefits, payments or denials _____ Other _____
_____ All of the above (Describe specific information)

I understand that authorized disclosures may have already occurred and that this revocation cannot apply retroactively to any disclosures. I understand that Federal or State law may require disclosure of protected health information.

UPREHS, its employees, officers, Depot Drug pharmacies, and Clinic physicians are hereby released from any legal responsibility or liability for disclosure of information I previously authorized.

Signature of member or member's legal representative Date
(Complete the form before signing)

(Print full name if member's legal representative) (Title or relationship to member)

NOTE: A copy of a notarized Power of Attorney may be submitted to authorize this revocation.

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Introduction

Welcome to the UPREHS Prime Medicare Prescription Drug Plan!

We are pleased that you've chosen to allow UPREHS to be your Part D Plan.

The UPREHS Prime Medicare Plan is a Medicare Prescription Drug Plan

UPREHS is contracted with the Centers for Medicare & Medicaid Services (CMS) as an Employee Group Waiver Plan (EGWP) direct contract Medicare Part D Prescription Drug Plan. Medicare must approve the UPREHS Plan each year. For current UPREHS Medicare members, you were automatically enrolled in our Plan so that UPREHS can continue to provide your prescription drug benefits. New plan members are enrolled when they become eligible for and enrolled in Medicare Parts A and B.

This Benefit Guide is part of our contract with you about how UPREHS covers your care. Other parts of this contract include your enrollment form, the Formulary (list of covered drugs) 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 UPREHS starting January 1, 2011 through December 31, 2011.

Throughout the remainder of this Benefit Guide, we may also refer to the UPREHS Prime Medicare Plan as "Plan, or "Our Plan."

This Benefit Guide explains how to get your Medicare Prescription Drug coverage through our Plan

This Benefit Guide, together with (your enrollment form for new enrollees), riders, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. It also explains our responsibilities to you. The information in this Benefit Guide is in effect for the time period from January 1, 2011 through December 31, 2011.

This Benefit Guide gives you the details, including:

- What is covered in our Plan and what is not covered.
- How to get your prescriptions filled, including some rules you must follow.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave our Plan, including your choices for continuing Medicare Prescription Drug coverage.

How to contact the UPREHS Customer Services

If you have any questions or concerns, please call or write to Customer Services. We will be happy to help you. Our Customer Services hours are 7:30 am to 3:30 pm, Mountain Time, Monday through Friday.

CALL	1-800-547-0421, this number is also on the cover of this Benefit Guide for easy reference. Calls to this number are free.
TTY/TDD	Please use 711, the national access number.
FAX	801-595-4399
WRITE	UPREHS, PO Box 165090, Salt Lake City, UT 84116-5090
WEBSITE	www.uphealth.com

How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline

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, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. CMS stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Prescription Drug Plans (including our Plan).

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

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free.

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

SHIP – an organization in your State that provides free Medicare help and information

SHIP stands for State Health Insurance Assistance Program. SHIPs are organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which State they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare Health Plans, and about Medigap (Medicare supplement insurance) policies.

You can find contact information for the SHIP in your State by calling Medicare at 1-800-633-4227. You can also find the Website for your local SHIP at www.medicare.gov.

Quality Improvement Organization – a group of doctors and health professionals in your State who review medical care and handle certain types of complaints from patients with Medicare

“QIO” stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each State. QIOs have different names, depending on which State they are in. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in the QIO review written quality of care complaints made by Medicare patients. See Section 6 for more information about complaints.

You can find contact information for the QIO in your State by calling Medicare at 1-800-633-4227.

Medicaid agency – State government agency that handles health care programs for people with low incomes

Medicaid is a joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact your specific State Medicaid office. You can find your State Medicaid office by calling Medicare at 1-800-633-4227.

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors’ benefits; and benefits for the aged, blind, and disabled. If you have questions about any of these benefits you can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

Railroad Retirement Board

Most UPREHS members receive their Medicare benefits through the Railroad Retirement Board. You can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 1-312-751-4701. You can also visit www.rrb.gov.

State Pharmacy Assistance Program

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

Section 1 Plan Basics

What is the UPREHS Prime Medicare Prescription Drug Plan?

UPREHS is contracted with the Centers for Medicare & Medicaid Services (CMS) as an Employer Group Waiver Plan (EGWP) direct contract Medicare Part D Prescription Drug Plan. Medicare must approve our contract each year. As an EGWP, our membership is available only to union members, Union Pacific Railroad or affiliated Railroad Medicare retirees and their spouse/widow/widower. CMS does not require an EGWP to perform some of the contractual requirements that apply to for-profit Part D plans because of our membership restriction. UPREHS was founded solely to serve you - our members. Current UPREHS Medicare members have been automatically enrolled in our Plan so that UPREHS can continue to provide your prescription drug benefits while you receive Medicare benefits. Now that you are enrolled in the UPREHS Prime Medicare Plan you are getting your Medicare Prescription Drug coverage through UPREHS. This Benefit Guide explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare Prescription Drug coverage

Medicare Prescription Drug coverage is insurance that helps pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a preferred Plan pharmacy, Medicare Part D covers it, and other coverage rules are followed. We do not pay for drugs under Medicare Part D that are covered by Medicare Part B. As a member, all you have to do is continue to pay your monthly premium and copayments. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. If you have limited income and resources, you may get extra help from Medicare to pay your premium, and copayments so that you get your prescription drugs for little or no cost. Please see Section 2 or call Customer Services to learn more.

- UPREHS has contracted with Ascend Specialty Drug Pharmacy as a preferred pharmacy. Ascend Specialty Drug Pharmacy provides your self-injectable medications (excluding insulin) that treat conditions such as Rheumatoid Arthritis, Multiple Sclerosis, Hepatitis-C, Cancer, Transplant and other conditions. Call 1-800-850-9122 and they will be happy to set up delivery of your medications. Your copayments will be the same as those from the Depot Drug Mail Pharmacy.

Help us keep your membership record up-to-date

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

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

What is the geographic service area for our Plan?

UPREHS is a National Medicare Prescription Drug Plan and includes the states of Alaska and Hawaii. Your UPREHS preferred pharmacies are the Depot Drug Mail Pharmacy, all Depot Drug Walk-In Pharmacies, and the Ascend Specialty Drug Pharmacy. You are limited to filling one 30-day supply (or less) per prescription from a UPREHS nonpreferred retail pharmacy. All maintenance prescriptions (medication taken longer than 30 days) must be filled through the Depot Drug Pharmacies. We cannot pay for any prescriptions that are filled by pharmacies outside of the United States, even for a medical emergency.

Use your combined UPREHS Health Insurance and Rx ID Card for prescriptions instead of your red, white, and blue Medicare card

As a member of our Plan, one card does it for you! You have a combined UPREHS Health Insurance and Rx ID Card. When obtaining prescriptions, use your UPREHS ID Card. You will need both your Medicare and UPREHS ID cards for your medical services.

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

Using plan pharmacies to get your prescription drugs covered by us

What are network pharmacies? With few exceptions, you must use the Depot Drug Pharmacies to get your prescription drugs covered.

- **What is a preferred pharmacy?** Our preferred pharmacies are the Depot Drug Mail Pharmacy, the Depot Drug Walk-In Pharmacies and the Ascend Specialty Drug Pharmacy. UPREHS owns the Depot Drug Pharmacies that were established solely to serve our members. You must use the Depot Drug Pharmacies for all maintenance prescriptions. Maintenance prescriptions are those taken longer than 30 days. We have negotiated a lower price from the drug manufacturers for covered prescription drugs than the price we pay for your drugs obtained at a nonpreferred network retail pharmacy. These savings are returned to you in the form of lower copayments and expanded Plan pharmacy benefits.
- **What is Ascend Specialty Drug Pharmacy – a preferred pharmacy?** UPREHS has added a valuable benefit for you that can change, for the better, the way you receive self-injectable and other medications (excluding insulin) that treat conditions such as Rheumatoid Arthritis, Multiple Sclerosis, and Hepatitis-C, and Cancer, Transplant and other conditions. Your copayments are the same as those from the Depot Drug Mail Pharmacy. Ascend experts will provide you with specialized care including educational materials and pharmacy counseling to help you understand your medication therapy.

You have the option to enroll in this additional benefit at no cost and have specialty medications delivered directly to you by Ascend. You will always be advised when to expect your shipment and most medications are shipped overnight via priority mail. In addition, you will be provided with unlimited access to expert skilled specialty pharmacy consultation.

If you currently take any of the above types of medications, this valuable benefit is yours and we hope you will take advantage of it right away. Call 1-800-850-9122 for more information.

- **What is a nonpreferred network retail pharmacy?** This is a pharmacy at which you can get your first 30-day prescription drug supply (or less) and emergency prescriptions using your Plan drug benefits. We call them nonpreferred network retail pharmacies because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of the Depot Drug Pharmacies. A nonpreferred network retail pharmacy is still a network pharmacy, but you have to pay more for your prescriptions. Nonpreferred network retail pharmacies are retail pharmacies in the UPREHS network and their price for covered prescription drugs is more than UPREHS pays. That is the reason that your copayments are higher if you use a nonpreferred network retail pharmacy.
- **What are covered drugs?** All Medicare Part D covered drugs are included in our formulary. A covered drug is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan.

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

To fill your prescription at a nonpreferred network retail pharmacy, you must show your UPREHS ID Card. If you do not have your ID card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting your prescription receipt to us along with a completed UPREHS Prescription Claim Form found in the *UPREHS Forms* section of this book. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

- If you must use a nonpreferred network retail pharmacy, ask your physician to write 2 prescriptions, a one-month supply to be filled at your local pharmacy and a long-term prescription to be filled through the Depot Drug Mail Pharmacy per the instructions in this section. When using a Depot Drug Walk-In Pharmacy, give the original to the pharmacist. They will enter the information about your prescription and you can obtain your refills from the Depot Drug Mail Pharmacy.

Finding a nonpreferred network retail pharmacy

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

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

Very rarely a pharmacy might leave our network. If this happens, you will have to get your prescriptions filled at another nonpreferred network retail pharmacy. Please call Customer Services to find another nonpreferred network retail pharmacy in your area.

How do I fill a prescription through the Depot Drug Pharmacies?

You get more out of your Medicare benefits by using the Depot Drug Mail Pharmacy. UPREHS is able to supply Mail Order Pharmacy prescriptions to you with lower copayments because of volume discounts from the drug manufacturers. These savings are passed on to you through lower Depot Drug Mail Pharmacy copayments and the enhanced benefits you receive under our Plan. Many different drug manufacturers produce medications and label the medication with their own brand name or produce a generic drug. Drugs are individually analyzed by UPREHS for quality, safety, and cost. Formulary list

selections are made and a large supply of the drug is purchased from one manufacturer to stock the Depot Drug Mail Pharmacy. The manufacturer gives a volume discount for the purchase of large drug quantities. Again, these savings are passed on to you through lower Depot Drug Mail Pharmacy copayments and the enhanced benefits you receive under our Plan.

You need to obtain your maintenance prescriptions from the Depot Drug Mail Pharmacy and the Depot Drug Walk-In Pharmacies. Maintenance prescriptions are those that you need to take longer than 30 days. UPREHS supplies your maintenance prescriptions with lower copayments and drug prices, so you get expanded benefit coverage.

How do I fill a prescription through Ascend Specialty Drug Pharmacy?

If you require specialty medications for the treatment of conditions such as Rheumatoid Arthritis, Multiple Sclerosis, Hepatitis-C, Cancer, Transplant and other conditions requiring self-injectable and other medications (excluding insulin), UPREHS has arranged for help for you. Ascend Specialty Drug Pharmacy will provide these medications to you at the same preferred copayment rate as the Depot Drug Mail Pharmacy. Your medications will be delivered directly to you by Ascend. You will always be advised when to expect your shipment and most medications are shipped overnight via priority mail. In addition, you will be provided with unlimited access to experts in skilled specialty pharmacy consultation. Ascend Care Coordinators work directly with your UPREHS Care Coordinators, UPREHS Customer Service Representatives, and Depot Drug Pharmacies and Clinics, to make certain that you receive the specialty medications that you require. If you have a prescription to fill soon, or if you have any questions, feel free to contact Ascend first at 1-800-850-9122 (toll free). They will be happy to coordinate with UPREHS, contact your doctor to obtain new prescriptions, and set up delivery of your medications.

Getting new prescriptions from the Depot Drug Mail Pharmacy

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

- Obtain your written prescription(s) from your doctor. Make certain the number of refills the doctor wants you to have is clearly indicated on your prescription. Your prescription can remain valid for up to one (1) calendar year, but it cannot be refilled after that time. If you continue to need the medication, you must get a new prescription from your doctor.
- Use a separate sheet of paper to show your name and UPREHS ID Card number exactly as they appear on your ID card, your return address, and your doctor's name and telephone number with the area code.
- Order a 3-month (90-day) supply for each prescription if possible. Be sure to specify whether you want a 3-month (90-day), 2-month (60-day), or 1-month (30-day) supply.
- Without copayment(s), your prescription(s) cannot be filled. You can pay by check or money order payable to the Depot Drug Mail Pharmacy. It is easier for you and UPREHS to pay your copayment with your debit or credit card. That way, you will not need to guess the amount of your copayment. To use your debit or credit card, write down the type of card (MasterCard or VISA only) and the entire debit or credit card number and expiration date of your card. Once your card number is on file with Depot Drug Mail Pharmacy, you do not need to send the number each time, just request that we use your debit or credit card on file for your copayment on future prescriptions. Allow ten (10) working days for mail delivery of your prescriptions. Debit or credit card payment is the most convenient way to pay your prescription copayments

when you don't know how much to pay. We tell you how much we applied to your debit or credit card for your copayment on your receipt.

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

Use the Depot Drug Mail Pharmacy

You must use the Depot Drug Mail Pharmacy for mail order prescription service (except for medications provided by the Ascend Specialty Drug Pharmacy). Prescription drugs that you get through any other mail order service are not covered. There are three ways to obtain prescription refills from the Depot Drug Mail Pharmacy.

Refills by mail

Your prescriptions are easy to refill once they are already on file with the Depot Drug Mail Pharmacy. UPREHS urges you to order a 3-month (90-day) supply depending on the number of refills left on your prescription. You may re-order another 3-month supply in 60 days, or more after your last 3-month refill so that you won't run out of your medication.

A convenient reorder form is included in each prescription sent to you. Simply indicate a one, two or three-month supply and your method of payment. If you are not using your debit or credit card, include a check or money order for your copayment and mail the form to the address indicated on the form.

Refills by telephone

Just call the UPREHS toll-free number, 1-800-547-0421, and follow the interactive voice response instructions. You must use your debit or credit card (MasterCard or VISA only) for copayments to order refills by telephone. To use the telephone refill service:

- Have your UPREHS ID card; your debit or credit card (MasterCard or Visa only) and the prescription number(s) to be refilled ready before you place your call.
- Call the Depot Drug Mail Pharmacy refill service telephone number toll free at 1-800-547-0421.
- Follow the instructions of the automated pharmacy service line to order your refill(s) and pay the copayment(s) using your debit or credit card.
- You may place your telephone order any day (including weekends and holidays) between the hours of 4 am and 11 pm, Mountain Time.

Refills using our Website

UPREHS offers you the convenience of ordering your prescription refills using our Website at www.uphealth.com. You must use your debit or credit card (MasterCard or Visa only) for Website ordering. To register on the UPREHS website, follow the instructions below. You can call UPREHS Customer Services at 1-800-547-0421 or email Help@uphealth.com if you need help.

Getting your password to use the UPREHS Website

- First, go to our home page at www.uphealth.com and choose *Member Login*.
- If you are not yet registered to use our Website, select *create one now* from the text paragraph.

- Fill in all of the blanks presented. When the computer matches this information to your membership file, your registration will be completed. You will receive a *Congratulations* notice.
- Your new password will be emailed to the email address that you used to register.
- Your website user name will be your Unique Member ID Number as shown on your UPREHS Health Insurance and Rx Card. Your assigned password will be made up of at least six digits including both letters and numbers.
- Once you receive your computer-assigned password, you will be able to change the password to one that you can more easily remember.

Back to ordering your prescription refills on the UPREHS Website:

Log in, now that you have your password.

- Choose *Member Login* from the home page and log in. *Customer Services and Information* will appear. From the listing on the left, click on *Order Rx refill* then *Begin*.
- Begin by selecting the prescription you want to refill; choose the number of months you want to refill and click on *Add to Rx shopping cart*.
- When you have entered all the prescriptions you want to order, click on *Begin checkout process*. You will be asked to enter your daytime telephone number and then to verify the last 4 digits of your debit or credit card and the expiration date. You may update or change your debit or credit card information, or if a debit or credit card is not on file, you may enter your card number and expiration date (**only MasterCard or Visa are accepted**).
- You will be asked to verify the prescriptions you have ordered, how many months supply, and the amount to be charged to your debit or credit card and the address to which the prescriptions will be shipped.
- At any time up to this point you can go back to edit your entries or cancel the entire order.
- You can then click on *Submit order for processing*, and the message at the top of the box will verify that you are *Finished*.

Filling prescriptions outside the network

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

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

If you do go to an out of network pharmacy for the reasons listed above, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you

for our share of the cost by submitting a paper claim completed by the pharmacy and your receipt for the medication with a letter explaining your situation to UPREHS at the address listed on the UPREHS Prescription Drug Claim Form. If you go to an out of network pharmacy, you are responsible for paying the applicable copayment and the difference between what we would pay for the medication and what the out of network pharmacy charged for your medication. You should submit a claim to us if you fill a prescription at an out of network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see Section 4). To learn how to submit a paper claim, please refer to the paper claims process described next.

How do I submit a paper claim to UPREHS?

When you get your prescriptions from a preferred Depot Drug Pharmacy, your claim is automatically submitted to UPREHS. If you go to an out of network pharmacy because of the reasons listed above, the pharmacy will not be able to submit the claim directly to us and you will have to pay the full cost of your prescription. You may have the pharmacy submit your claim using the UPREHS Prescription Drug Claim Form found in the *UPREHS Forms* section of this book. Please submit your form, your receipt and your letter explaining your situation to the following address:

Depot Drug Pharmacy, PO Box 165090, Salt Lake City, UT 84116-5090

Upon receipt, we will make an initial coverage determination on your request. If we determine that we should cover the prescription, and the paper claims form is completed by the pharmacy, we will mail our payment for our cost of the drug directly to you within 14 days of receipt of the completed form. All paper claims received will be paid at the UPREHS U&C Depot Drug pharmacy contract rate and the applicable Tier co-payment will be applied based on your Part D benefit level. If UPREHS Depot Drug does not have a contract rate on a medication UPREHS will default to our Usual and Customary rate of AWP minus 18% for name brand or AWP minus 25% for generic per Medicare's instructions. Your receipt does not contain all of the information that Medicare requires us to have for a coverage determination. (Please refer to Section 7 for more information about initial coverage determinations.)

To receive our coverage determination and possible payment for vaccine and administration costs from your physician that is not covered by Medicare Part B, please have your physician copy, complete and mail the Prescription Drug Claim Form found in the *UPREHS Forms* section of this book. You may contact our Customer Services at 1-800-547-0421. They will supply you and/or your physician with a paper claim form that gives us the information that Medicare requires that we have in order to pay for your vaccine and administration costs.

Home Infusion Pharmacies

It is our policy to contract with any willing Home Infusion Pharmacy that meets State, Federal and UPREHS requirements to become a network HI Pharmacy. UPREHS requires that you, your representative or the Home Infusion Pharmacy immediately contact UPREHS Customer Services if you find the need for HI therapy. We will direct you to the nearest network HI Pharmacy. UPREHS usually cannot supply Home Infusion therapy drugs so you must use one of our HI network pharmacies. We will cover HI drugs that are not obtained through either of these sources on a temporary basis if the need is urgent. The UPREHS Prime Medicare Plan will cover home infusion therapy if:

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

Long-term Care Pharmacies

UPREHS provides maintenance (taken longer than 30-days) Long Term Care drugs through the Depot Drug Mail Pharmacy if you choose. We have many Long Term Care network pharmacies through our network that provide drugs not available from Depot Drug Mail Pharmacy. If you choose to obtain your Long Term Care drugs from the Depot Drug Mail Pharmacy, you, your representative, or your doctor may call UPREHS Customer Services at 1-800-547-0421 and we will help you.

UPREHS has a national pharmacy network, but it is impossible for us to contract with every LTC pharmacy in the nation. Therefore, UPREHS has made maintenance LTC formulary drugs available to all members through our Depot Drug Mail Pharmacy. It is our policy to contract with any willing LTC pharmacy that meets State, Federal and UPREHS requirements to become a nonpreferred network LTC Pharmacy.

UPREHS will cover Long Term Care drugs that are not obtained through either of these sources on a temporary basis if the need is urgent. For more information, please contact Customer Services.

Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) Pharmacies through our network pharmacy and in limited areas.

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

Some vaccines and drugs may be administered in your doctor's office

We may cover vaccines that are preventive in nature and their administration by your doctor that are not already covered by Medicare Part B. In addition we cover some drugs that may be administered in your doctor's office. (Please see Section 4, *How does your enrollment in our Plan affect coverage for drugs covered under Medicare Part A or Part B?* for more information.)

To receive our coverage determination and possible payment for vaccine and administration costs from your physician that is not covered by Medicare Part B, please see the *UPREHS Forms* section of this book. Your physician can copy the UPREHS Prescription Drug Claim Form and submit a claim for vaccine and administration directly to UPREHS. You can contact our Customer Services at 1-800-547-0421. They will supply you and/or your physician with this claim form that gives us the information that Medicare requires that we have in order to pay for your vaccine and its administration.

Section 2 Extra Help with Drug Plan Costs for People with Limited Income and Resources

What extra help is available?

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 monthly premium and/or prescription copayments.

Do you qualify for extra help?

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

1. You automatically qualify for extra help and don't need to apply. If you have full coverage from a State Medicaid program, get help from Medicaid paying your Medicare premiums, or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.
2. You apply and qualify. You may qualify if your yearly income is less than the amount determined by the Federal government for qualification. 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.ssa.gov on the Web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0788. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher.

How your costs change when you qualify for extra help

The extra help you get from Medicare will help you pay for your premium and prescription copayments. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will mail you a *Coverage Rider* that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, the amounts you pay can also change.

How you get more information

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.ssa.gov on the Web.

You can also look at your *2011 Medicare & You* book, visit www.medicare.gov on the Web, or call Medicare at 1-800-633-4227. TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please call our Customer Services at 1-800-547-0421.

Section 3 Plan Premium

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

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

2011 UPREHS Prime Medicare Secondary Plan, and Prime Medicare Part D Prescription Plan members pay a combined premium for all Medicare Plans of \$220 each month.

There are two ways to pay your monthly plan premium.

- **Option one – pay quarterly:** Pay your Plan premium quarterly (3 months at a time) by check, money order, or automatic premium deduction from your checking or savings account. If you pay by check or money order, we must receive your payment by the first of the month of every January, April, July, and October beginning with January 1, 2011. If you choose automatic deductions, we will debit your bank account on the second Monday of every December, March, June, and September.

UPREHS charges a \$20 service fee for checks returned or automatic premium payments rejected because of insufficient funds.

If you have any questions about signing up for the automatic premium payment option, to receive an authorization form, your Plan premiums or the different ways to pay them, please call our Customer Services at 1-800-547-0421.

- **Option two – pay monthly:** You can pay your Plan premium monthly through automatic premium deduction from your checking or savings account. We cannot accept monthly payments sent directly to UPREHS. We offer payment of your combined UPREHS Medicare Plans premiums monthly only if you have the amount automatically deducted from your bank account. If you do not have a checking account you can use your savings account. Monthly payments must be made through automatic bank account withdrawals. We cannot accept monthly payments sent directly to us.

If you have any questions about signing up for the automatic premium payment option, to receive an authorization form, your Plan premiums or the different ways to pay them, please call our Customer Services at 1-800-547-0421.

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

If your Plan premiums are past due, we will tell you in writing within 15 days. Medicare requires us to disenroll you in our plan after the second month of failure to pay your past-due plan premiums. **If you are disenrolled from UPREHS for any reason including nonpayment of your premium, you may not have another opportunity to enroll again.** Also, if you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Enrollment Period, unless you qualify for a Special Enrollment Period. If you do not qualify for a Special Enrollment Period or have another source of creditable prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage. Please see Section 8 for more about enrollment periods.

Can your Plan premiums change during the year?

Generally, your Plan premium cannot change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your Plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1, 2011.

In limited circumstances, your Plan premium may change during the calendar year. If you aren't currently receiving extra help but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your Plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income, resources, if you get married, or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for extra help, your monthly premium amount would be lower. The Social Security Administration or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help.

Do you have to continue to pay your Part A or Part B premiums?

To be a member of our Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. You must pay your Part B premiums. If you currently pay a premium for Medicare Part A (most people don't) and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a member of our UPREHS Medicare Plans.

What is the late enrollment penalty?

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

1. You were eligible to enroll in a Medicare Prescription Drug Plan; and
2. After the end of your initial enrollment period, there was a continuous period of 63 days or longer in which you were not enrolled in a Medicare Prescription Drug Plan or other creditable prescription drug coverage.
3. *Creditable prescription drug coverage* is coverage that is at least as good as the standard Medicare Prescription Drug coverage that expects to pay, on average, at least as much as the Medicare Prescription Drug benefit expects to pay.

You pay this late enrollment penalty for as long as you have Medicare Prescription Drug coverage. The amount of the late enrollment penalty may increase every year.

The late enrollment penalty does not apply to individuals who qualify for extra help with their drug plan costs.

NOTE: Many Medicare-eligible UPREHS members are still active workers with the Union Pacific Railroad. You will NOT be assessed the late enrollment penalty when you decide to retire and enroll in Medicare because you have *creditable prescription drug coverage* under the UPREHS Active Health Plan coverage.

Section 4 Prescription Drug Coverage

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

What is a formulary?

We have a formulary that lists all drugs that we cover. For 2011, we have included ALL covered Medicare Part D drugs in our formulary. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary; the prescription is filled through our preferred Depot Drug Pharmacies or at a nonpreferred network retail pharmacy (30-day supply only), it is a covered Medicare Part D drug, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on certain drugs. These requirements and limits are described in detail in your Formulary Book and in this Section.

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

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

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

If you need your prescription filled urgently, you may have a one-time-only fill at a nonpreferred network retail pharmacy. Any additional refills must go through the Depot Drug Mail Pharmacy with the exception of certain specialty drugs obtained through the Ascend Specialty Drug Pharmacy and certain drugs with Quantity Limits set by State or Federal law. Ask your physician to write 2 prescriptions for you: a one-month supply to be filled at a nonpreferred network retail pharmacy and a long-term prescription to send to the Depot Drug Mail Pharmacy.

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

You have been sent a 2011 UPREHS Prime Medicare Plan Preferred Drug Formulary Book with all tier 1, 2 and 4 preferred formulary drugs listed. If the Part D drug is not in those tiers, it is in tier 3, nonpreferred formulary drugs. All covered Medicare Part D drugs are on your formulary. Since a formulary can change at any time, if there is any question about drug coverage, you must call Customer Services for clarification at 1-800-547-0421. You can also get updated information about the drugs covered by us by visiting our Website at www.uphealth.com.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your copayment depends on which drug tier your drug is in. The table below shows the copayment amount you pay for each tier when you are in your initial coverage limit and when you obtain your prescription from the Depot Drug Mail Pharmacy, Depot Drug Walk-In Pharmacies, Ascend Specialty Drug Pharmacy, or a

nonpreferred network retail pharmacy. As you can see, your benefits are stretched through lower copayments and lower drug prices when you obtain your prescriptions from the Depot Drug Mail Pharmacy. We are able to pass our quantity discounts back to you in the form of expanded benefits, lower copayments, and lower charges for your drugs.

2011 Copayment chart for drug tiers

2011 30-Day Copayment Amounts for Part D Drugs	Tier 1 Generic Drugs 30-Day	Tier 2 Brand Preferred 30-Day	Tier 3 Brand Non- Preferred 30-Day	Tier 4 Specialty Drugs 30-Day
Depot Drug Mail Pharmacy Preferred Pharmacy \$\$\$ Your Best Money Saver 30, 60 or 90-Day Supplies Available	\$3	\$15	Higher of \$40 or 33% of drug cost	Higher of \$50 or 33% of drug cost
Ascend Specialty Drug Mail Pharmacy - Preferred Pharmacy for chronic diseases requiring self-injectable medications, and those for oncology (cancer) or transplant (not insulin) \$\$\$ Your Best Money Saver 30-Day Supply Available	\$7	\$20	Higher of \$40 or 33% of drug cost	Higher of \$50 or 33% of drug cost
Depot Drug Walk-In Pharmacies Preferred Pharmacies \$\$\$ Your Best Money Saver	\$7	\$20	Higher of \$40 or 33% of drug cost	Higher of \$50 or 33% of drug cost
National Retail Pharmacy Network Non-Preferred Pharmacies 30-Day or less Supply Only	\$15	\$30	Higher of \$50 or 33% of drug cost	Higher of \$100 or 33% of drug cost
Out-of-Network Pharmacy - Emergency Only We refund you the UPREHS cost for the Part D drug minus your tier copayment amount. You pay any charges above UPREHS cost. Non-Part D drugs are not covered.	\$15	\$30	Higher of \$50 or 33% of drug cost	Higher of \$100 or 33% of drug cost
If the actual cost of a drug is less than the Tier copayment amount for that drug, you will pay the actual cost plus dispensing fee, not the copayment! Some “\$4” drugs would cost you less under this rule so make sure that you use your UPREHS ID Card!				

Can the formulary change?

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

possible. Formulary changes are also available by calling Customer Services at 1-800-547-0421 or visiting our Website at www.uphealth.com.

What if your drug is not on the formulary?

All Part D drugs are on the UPREHS formulary. If Medicare Part D covers your drug, it is included in our formulary. The UPREHS formulary includes all covered Medicare Part D drugs. You can contact Customer Services at 1-800-547-0421 to be sure if a drug is covered.

If Customer Services confirms that Medicare Part D does not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by Medicare. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please show him/her your Formulary Book or contact Customer Services.
- You can ask us to make an exception to cover your drug **only** if it is a Medicare-covered Part D drug, and all of those are on our Plan formulary.
- You can pay out of pocket for the drug and request that our Plan reimburse you by requesting a formulary exception if the drug is covered by Medicare Part D. Since ALL Part D drugs are on the UPREHS formulary, this would rarely apply. This does not obligate our Plan to reimburse you if the exception request is not approved. See Section 7 for more information on how to request an appeal.

If you transition into UPREHS from another plan

If you recently joined our Plan and learn that Medicare Part D does not cover a drug you were taking when you joined our Plan, you can call Customer Services to see if there is another drug to treat your medical condition. If we cover another drug, you can ask your doctor if this drug is an option for your treatment.

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

In some instances, we may cover the drug in certain cases during the first 30 days of new membership.

What types of drugs does Medicare or UPREHS not cover?

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

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject

- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

In addition, a Medicare Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B. See: *How does your enrollment in our Plan affect coverage for drugs covered under Medicare Part A or Part B?* in this section.

Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration. Congress specifically lists the reference books that are used. If the use is not supported by one of these references (known as compendia), then the drug is a non-Part D drug and is not covered by Medicare or our Plan. These compendia are The American Hospital Formulary Service Drug Information, United States Pharmacopoeia Drug Information and the DRUGDEX Information System.

There are some restrictions on coverage for some drugs

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

- **Prior Authorization:** We require you to get prior authorization for ALL compounded drugs. This means that you, your representative, or your doctor will need to get approval from us before you fill your prescription. If they don’t get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. These limitations are usually placed because of State or Federal requirements. For example, we provide 18 tablets per prescription for Imitrex.
- **Generic Substitution:** When there is a generic version of a name brand drug available, we will automatically give you the generic version. Brand name drugs with generic versions are usually found in a higher tier copayment on our formulary. If your doctor tells you that you must take the brand name drug, it is still available to you, but at a higher copayment.

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

Programs on drug safety

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

- Possible medication errors.

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

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

Program to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

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

If we have a program that 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 your participation in the program.

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

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

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

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

If you qualify for extra help with your drug costs, your costs may be different than those described below. See Section 2: *Extra Help with Drug Plan Costs for People with Limited Income and Resources* and the *Evidence of Coverage Rider for those who get extra help paying for their prescription drug* for more information.

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

Deductible

On your behalf, UPREHS pays your 2011 annual deductible of \$310. This is the amount that must be paid each year before Medicare will begin paying for part of your drug costs. After UPREHS meets the deductible for you, you will continue to have benefits available until you reach the initial coverage limit of your benefits. During the deductible period, your copayments apply to your out of pocket expenses for Medicare Part D covered drugs.

Initial Coverage Benefit Stage

NEW: A \$9 copayment gets you a 90-day supply of any Tier 1 Generic drug from the Depot Drug Mail Pharmacy while you are in your Initial Coverage benefit stage. That is just \$3 for each 30-day supply. Don't let the so-called \$4 drugs fool you!

You must continue to obtain your prescription drugs through the preferred Depot Drug Mail Pharmacy and Depot Drug Walk-In Pharmacies, or Ascend Specialty Drug Pharmacy during all stages of your Medicare Part D benefit year.

During the initial coverage benefit stage, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the copayment. Your copayment will vary depending on the drug and where the prescription is filled per the chart below. As you can see, your out of pocket costs are much less when you use the preferred Depot Drug Mail Pharmacy, a Depot Drug Walk-In Pharmacy, or Ascend Specialty Drug Pharmacy. That is because we are able to pass our volume discounts back to you in the form of lower copayments and expanded benefits.

Once your total drug costs reach \$2,840 you will have reached the end of your initial coverage benefit stage. Your initial coverage limit is calculated by adding payments made by our Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under our Plan, the amount they spend may count towards your initial coverage limit.

Out of Pocket Stage (Coverage Gap) after you reach your Initial Coverage Limit and before you qualify for Catastrophic Coverage

You must continue to obtain your prescription drugs through the preferred Depot Drug Mail Pharmacy and Depot Drug Walk-In Pharmacies, or Ascend Specialty Drug Pharmacy during all stages of your Medicare Part D benefit year.

During the coverage gap stage, you receive a discount on brand name drugs and pay only 93% of the costs of generic drugs. Beginning in 2011, the Medicare Coverage Gap Discount Program will provide manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee) will be available for those brand name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount at the Depot Drug Pharmacies, Ascend Specialty Pharmacy, and nonpreferred retail pharmacies when your prescriptions are filled. This information will also be displayed when you request an Explanation of Benefits.

It is even more important for you to use Depot Drug Mail Pharmacy because the 50% amount discounted by the manufacturer counts toward your out-of-pockets costs as if you had paid this amount and moves you through the coverage gap. If you use an out of network pharmacy, we cannot guarantee that you will receive the 50% discount, or credit for your out of pocket costs.

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 Services (phone numbers are on the front cover).

After your total drug costs under your initial coverage limit reach \$2,840 you, or others on your behalf, will pay 100% for your drugs until your total out of pocket costs reach \$4,550 and then you will qualify for catastrophic coverage.

Catastrophic Coverage

You must continue to obtain your prescription drugs through the preferred Depot Drug Mail Pharmacy, Depot Drug Walk-In Pharmacies, and Ascend Specialty Drug Pharmacy during all stages of your Medicare Part D benefit year.

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4,550 out of pocket for the year. When the total amount you have paid in copayments and out of pocket costs for covered Medicare Part D drugs reaches \$4,550, you will qualify for catastrophic coverage. During catastrophic coverage you will pay the greatest of 5% of drug costs (coinsurance), \$2.50 for generic drugs, or \$6.30 for brand name drugs and we will pay the rest. Once you are in the catastrophic coverage stage, you will stay in this stage for the rest of the year.

How is your out of pocket cost calculated?

The following types of payments for prescription drugs can count toward your out of pocket costs and help you qualify for catastrophic coverage so long as the drug is normally covered by Medicare Part D, on our Plan formulary, and it was obtained through the preferred Depot Drug Mail Pharmacy, Depot Drug Walk-In Pharmacy, Ascend Specialty Drug Pharmacy, or at a nonpreferred network retail pharmacy (30-day supply only), or you have an approved emergency claim from an out of network pharmacy:

- Your copayments and;
- Payments you make after your initial coverage limit.
- **It is even more important for you to use Depot Drug Mail Pharmacy because the 50% amount discounted by the manufacturer counts toward your out-of-pockets costs as if you had paid this amount and moves you through the coverage gap. If you use an out of network pharmacy, we cannot guarantee that you will receive the 50% discount, or credit for your out of pocket costs.**

When you have spent a total of \$4,550 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level. Purchases that will **not** count toward your out of pocket costs:

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

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

Except for your premium payments, any payments you make for Medicare Part D drugs covered by us count toward your out of pocket costs and will help you qualify for catastrophic coverage. In addition,

when the following individuals or organizations pay your prescription drug costs, these payments will count toward your out of pocket costs (and will help you qualify for catastrophic coverage):

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

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

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

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

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

Explanation of Benefits

An Explanation of Benefits (EOB) is a document you will get if you request one from Customer Services at 1-800-547-0421. UPREHS does not send EOB's unless you request one. The information detailed on an EOB will be our current record of all of your prescription benefits provided to you up to the day of your request. The EOB is subject to change at any moment and may not reflect your current benefit accurately if you have obtained any prescriptions from a nonpreferred network retail pharmacy, an out of network pharmacy, a LTC pharmacy has not submitted their claims, or received vaccine from your physician. When you use those benefit sources, your benefit information is not provided to UPREHS through instant tracking and they cause your benefit levels to be inaccurate.

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

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as they are not covered by Medicare Part A or B, they are a covered Medicare Part D drug, and you obtain your maintenance prescriptions through the preferred Depot Drug Mail Pharmacy, Ascend Specialty Pharmacy or a nonpreferred Long Term Care Pharmacy. Drugs that cannot be supplied by the Depot Drug Mail Pharmacy may be obtained through the skilled nursing facility's Long Term Care Pharmacy *if* it is in our nonpreferred retail network.

When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave our Plan and join a new Medicare Prescription Drug Plan.

Section 5 If You Have Other Prescription Drug Coverage

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

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

Medicare law requires us to collect this information from you when you or your spouse enrolls in UPREHS Medicare Plans. You will find a copy of the UPREHS COB Form in the *UPREHS Forms* section of this book. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Customer Services at 1-800-547-0421 to update your membership records.

If you have Medicare and Medicaid

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

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

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

SECTION 6 Making Complaints

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 7.

The formal name for making a complaint is filing a grievance.

- A complaint is also called a grievance.
- Another term for making a complaint is filing a grievance.
- Another way to say, using the process for complaints is using the process for filing a grievance.

Problems that are handled by the complaint process

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

If you have any of these kinds of problems, you can make a complaint:

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

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

The process of asking for a coverage decision and making an appeal is explained in Section 7 of this book. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

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

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

Step-by-step process for making a complaint

STEP 1

Contact us promptly – either by phone or in writing

- Usually, calling Customer Services is the first step. If there is anything else you need to do, Customer Services will let you know. We can usually resolve any complaint or problem you may have on the telephone.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you do this, it means that we will use our *formal procedure* for answering grievances.
 - We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.
- Whether you call or write, you should contact Customer Services 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. What this section calls a fast complaint is also called a fast grievance.

STEP 2

UPREHS looks into your complaint and gives you an answer.

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

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

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

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

Section 7 Complaints and Appeals about your Part D Prescription Drugs

Introduction

This section explains how you ask for coverage of your Part D drug(s) or payments in different situations. These types of requests and complaints are discussed below in Part 1.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1 are considered **grievances**. You would file a grievance if you have any type of problem with us, or one of our network providers that does not relate to coverage for Part D drugs. For more information about grievances, see Section 6.

PART 1. Requests for Part D drugs

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

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

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug you need, or paying for a Part D drug you already received. Initial decisions about Part D drugs are called **coverage determinations**. With this decision, we explain whether we will provide the Part D drug you are requesting, or pay for the Part D drug you already received.

The following are examples of requests for initial determinations:

- You ask us to pay for a Medicare Part D prescription drug you have received.
- You ask for an exception to our utilization management tools - such as requesting additional drugs that have a Quantity Limit.
- You ask for a Tier 3 non-preferred Part D drug at the preferred cost-sharing level of Tier 2. This is a request for a tiering exception. See "What is an exception?" below for more information about the exceptions process.
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office will be covered UPREHS. See *Filling Prescriptions Outside of Network* in Section 2 for a description of these circumstances.

What is an exception?

An exception is a type of initial determination (also called a coverage determination") involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- All Medicare Part D drugs are included in the UPREHS formulary, therefore, there are no exceptions to the UPREHS formulary.

- Excluded drugs cannot be covered by Medicare Part D. Medicare Part D will not make an exception to excluded drugs.
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more.
- You may ask us to provide a higher level of coverage for your Part D drug. If your Part D drug is contained in our Tier 3, you may ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2. This would lower the copayment amount you must pay for your Part D drug.
- You may not ask for an exception to drugs that are in Tier 1, 2 or 4.

We will only approve your request for an exception if the alternative preferred Part D drugs included in Tiers 1, 2, or 4 would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

You may call Customer Services at 1-800-547-0421 to ask for any of these requests.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your appointed representative. You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed on the cover of this book. To learn how to name your appointed representative, you may call Customer Services or use the *Appointment of Representative* form in the front of this book.

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

Asking for a standard or fast initial determination

A decision about whether we will give you, or pay for, the Part D drug you are requesting can be a standard decision that is made within the standard time frame, or it can be a fast decision that is made more quickly. A fast decision is also called an expedited decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug you, your doctor, or your representative should call, fax, or write us at the numbers or address listed on the cover of this book.

Asking for a fast decision

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

If you are requesting a Part D drug that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers on the cover of this book.

Be sure to ask for a fast or expedited decision. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a fast grievance. You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see 5). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a standard initial determination about a Part D drug (including a request to pay you back for a Part D drug that you have already received).
 - Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for a tiering exception, or an exception from utilization management rules – such as quantity limits, we must give you our decision no later than 72 hours after we receive your physician's supporting statement explaining why the drug you are asking for is medically necessary.
 - If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.
- For a fast initial determination about a Part D drug that you have not yet received.
 - If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's supporting statement, which explains why the drug you are asking for is medically necessary.
 - If we decide you are eligible for a fast review and you have not received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).
 - We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's supporting statement. If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request (or supporting statement if your request involves an exception).
- For a fast decision about a Part D drug that you have not yet received.
 - We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's supporting statement.

What happens if we decide against you?

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

Appeal Level 1: Appeal to UPREHS

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about a Part D drug is also called a plan **redetermination**. When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

How soon must you file your appeal?

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

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal about a Part D drug a signed, written appeal request must be faxed to the number or sent to the address listed on the cover of this book.

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part D drug that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed on the cover of this book.

Be sure to ask for a fast or expedited review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a fast grievance. You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 5. If we deny your request for a fast appeal, we will give you a standard appeal.

Getting information to support your appeal

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

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed on the cover of this book. You may also deliver additional information in person to UPREHS at 1040 North 2200 West Suite 200, Salt Lake City, Utah 84116.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed on the cover of this book.

How soon must we decide on your appeal?

- For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.
 - We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2.
- For a fast decision about a Part D drug that you have not yet received.
 - We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).
 - We must cover the Part D drug you requested as quickly as your health requires, but no later than 7 calendar days after we receive the request. If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.
- For a fast decision about a Part D drug that you have not yet received.
 - We must cover the Part D drug you requested no later than 72 hours after we receive your request.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity.

How to file your appeal

If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.
- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

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

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part D drug does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section *Favorable Decisions by the ALJ, MAC, or a Federal Court Judge* below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

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

If the Council decides in your favor:

See the section *Favorable Decisions by the ALJ, MAC, or a Federal Court Judge* below for information about what we must do if the MAC reverses our decision denying what you asked for.

Appeal Level 5: Federal Court

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

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

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

A Federal Court will not review your appeal request if the dollar value of the requested Part D drug does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

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

If the Judge decides in your favor:

See the section **Favorable Decisions by the ALJ, MAC, or a Federal Court Judge** below for information about what we must do if a Federal Court Judge reverses our decision denying what you asked for.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.
- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

Section 8 Leaving our Plan and Your Choices for Continuing Prescription Drug Coverage after You Leave

When can you end your membership in UPREHS?

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

You can choose to disenroll from our Plan from October 15 through December 7 for 2011. In certain cases, such as if you enter a nursing home, you can disenroll from our Plan at other times. After you request to disenroll, we will let you know in writing the date your coverage ends. If you don't get a letter, call Customer Services and ask for the date.

What is disenrollment?

As a UPREHS HCPP & Medicare Secondary Plan member, you are automatically enrolled in the UPREHS Prime Medicare Plan each year. If you choose to disenroll during the Annual Coordinated Enrollment Period, you may not be allowed to join a UPREHS Medicare plan again and you will also lose your UPREHS HCPP & Medicare Secondary Plan membership.

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

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

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

Until your membership with the UPREHS Plan ends, use our preferred Depot Drug Mail and Depot Drug Walk-In Pharmacies to fill your prescriptions

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

If you have any questions about your prescription drug coverage with our Plan, please call our Customer Services at 1-800-547-0421.

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

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

As a UPREHS HCPP & Medicare Secondary Plan member, you are automatically enrolled in the UPREHS Prime Medicare Plan each year. If you choose to disenroll during the Annual Coordinated Enrollment Period, you may not be allowed to join a UPREHS Medicare plan again and you will also lose your UPREHS HCPP & Medicare Secondary Plan membership.

- When is the Annual Enrollment Period? This happens from November 15 to December 31 in 2010. In 2011, it will be October 15 to December 7.
- What type of plan can you switch to during the Annual Enrollment Period? During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare prescription drug plan.
 - Original Medicare *without* a separate Medicare prescription drug plan.
 - – *or* – A Medicare Advantage plan. A Medicare Advantage plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage plans also include Part D prescription drug coverage.
- **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is at least as good as Medicare’s standard prescription drug coverage.)
- When will your membership end? Your membership will end when your new plan’s coverage begins on January 1.

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

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

- Who is eligible for a Special Enrollment Period? If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - If you have Medicaid.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.
 - If you live in a facility, such as a nursing home.
- When are Special Enrollment Periods? The enrollment periods vary depending on your situation.
- What can you do? If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare prescription drug plan.
 - Original Medicare *without* a separate Medicare prescription drug plan.

- A Medicare Advantage plan. A Medicare Advantage plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage plans also include Part D prescription drug coverage.
- As a UPREHS HCPP & Medicare Secondary Plan member, you are automatically enrolled in the UPREHS Prime Medicare Plan each year. If you choose to disenroll during the Annual Coordinated Enrollment Period, you may not be allowed to join a UPREHS Medicare plan again and you will also lose your UPREHS HCPP & Medicare Secondary Plan membership.
- When will your membership in UPREHS end? Your membership will usually end on the first day of the month after we receive your request to change your plan.

How do you end your membership in UPREHS?

As a UPREHS HCPP & Medicare Secondary Plan member, you are automatically enrolled in the UPREHS Prime Medicare Plan each year. If you choose to disenroll during the Annual Coordinated Enrollment Period, you may not be allowed to join a UPREHS Medicare plan again and you will also lose your UPREHS HCPP & Medicare Secondary Plan membership.

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods. There are a couple of exceptions:

- One exception is when you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact UPREHS Customer Services and ask to be disenrolled from our plan.
- Another exception is if you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop your Medicare prescription drug coverage.
- You may also disenroll by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You may only disenroll during the Annual Coordinated Enrollment Period unless you qualify for a Special Enrollment Period.

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

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires our Plan to disenroll you. In addition, if you are disenrolled from our Plan for misrepresentation of third party reimbursement, our Plan has the right to decline you future enrollment in our Medicare plans. This disenrollment would include disenrollment from the UPREHS HCPP & Medicare Secondary Plan.
- If you become incarcerated.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan.
 - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 30 days. See Section 3.
 - We must notify you in writing that you have 30 days to pay the plan premium and any past due amounts before we end your membership.

If you move out of our Plan's service area

UPREHS Prime Medicare Plan is a national plan. If you move permanently outside of the United States, please call our Customer Services at 1-800-547-0421. If you move permanently out of the United States, you will need to leave (disenroll from) our Plan. An earlier part of this section tells about the choices you have if you leave our Plan and explains how to leave.

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

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

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

If we ask you to leave our Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 6 for more information.

Section 9 Your Rights and Responsibilities as a Member of our Plan

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 9, we explain your Medicare rights and protections as a member of our Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have.

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. You can also reach the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area.

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

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

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). UPREHS does not have your medical records – your healthcare provider keeps them. You also have the right to ask your healthcare provider to make additions or corrections to your medical records (if you ask them to do this, they will review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call our Customer Services 1-800-547-0421.

NOTE: As a member of UPREHS, your 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.

Your right to get your prescriptions filled within a reasonable period of time

As explained in this Benefit Guide, you should get all of your prescriptions filled from the preferred Depot Drug Mail Pharmacy, a Depot Drug Walk-In Pharmacy, or Ascend Specialty Drug Pharmacy. You have the right to timely access to your prescriptions. Timely access means that you can get your prescriptions filled within a reasonable amount of time. Section 1 explains how to use the preferred Depot Drug Mail Pharmacy, the Depot Drug Walk-In Pharmacies, the Ascend Specialty Drug Pharmacy, or a nonpreferred network pharmacy to get a temporary prescription filled.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Therapy Management Programs we offer and in which you may participate if you meet certain criteria. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a pharmacy has denied coverage for a Medicare Part D drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision. Initial decisions are discussed in Section 7.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. Appeals and grievances are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and grievances are discussed in Section 7. If you make a complaint, we must treat you fairly (not discriminate against you).

Your right to get information about your drug coverage and costs

This Benefit Guide tells you what you have to pay for prescription drugs as a member of our Plan. If you need more information, please call our Customer Services at 1-800-547-0421. You have the right to an explanation from us about any bills you may get for drugs that are covered by Medicare Part D and/or our Plan. We must tell you why we will not pay for a Medicare Part D drug, and how you can file an appeal to ask us to change this decision. See Section 7 for more information about filing an appeal.

Your right to get information about our Plan and our preferred and nonpreferred network pharmacies

You have the right to get information from us about UPREHS and the UPREHS Prime Medicare Plan. This includes information about our financial condition and about our preferred and nonpreferred network pharmacies. To get any of this information, call Customer Services at 1-800-547-0421.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call our Customer Services at 1-800-547-0421. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP. The Introduction section tells how to contact the SHIP in your State. The Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

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

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Customer Services at 1-800-547-0421. You can also get help from your State Health Insurance Assistance Program, or SHIP. The Introduction section tells how to contact the SHIP in your State.

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

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

- Get familiar with your covered drugs and the rules you must follow to get these covered drugs. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
 - Sections 1 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 Services to let us know.
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called coordination of benefits because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it.
- Tell your doctor and pharmacist that you are enrolled in our plan. Show your plan membership card whenever you get your Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- Pay what you owe. As a plan member, you are responsible for these payments:
 - Pay your UPREHS premiums.
 - For some 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. Section 4 tells 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.
 - Pay your Medicare Part B premium.
- Tell us if you move. If you are going to move, it's important to tell us right away. Call Customer Services (phone numbers are on the cover of this booklet).

- Call Customer Services at 1-800-547-0421 for help if you have questions or concerns, problems, or suggestions.

Section 10 Legal Notices

Notice about governing law

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

Notice about nondiscrimination

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

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

As a Member in the Union Pacific Railroad Employees Prescription Drug Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at our Plan Administrator's office and at other specified locations all Plan documents, including copies of all documents filed by our Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to our Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of our Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duty upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a healthcare benefit or exercising your rights under ERISA. If your claim for a healthcare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty days, you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a State or Federal court. If it should happen that Plan Fiduciaries misuse our Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal

fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees: for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this Statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, US Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210.

Name of Plan	Union Pacific Railroad Employes Health Systems (the “Plan”)
Plan Sponsor	Union Pacific Railroad Company
Plan Identification Numbers	Employee Identification Number (EIN): 87-0427760 Plan Number (PN): H4652 & E7316
Plan Administrator	Union Pacific Railroad Employes Health Systems 1040 North 2200 West Suite 200 Salt Lake City, UT 84116 Telephone: (801) 595-4300 Fax: (801) 595-4399
Type of Plan	Health Care Benefit Plan; HCPP & Medicare Secondary, and Medicare Prescription Drug Plan
Trustee	Zions First National Bank 102 S Main Street Salt Lake City, UT 84101
Current Board of Trustees of Plan	M. Young, Chairman T. Graumann E. Weber S.R. Hirschbein R. Orosco R. Draskovich A. Nowlin H. Doucett M. H. Williams D. R. Albers C. A Scott
Operating Trustees	M.A. Young, Chairman D.T. Butterfield, Chief Executive Officer K.J. Potts, Vice President R. B. Egan, Vice President
Agent for Service of Legal Process	Service of Legal Process may be made upon our Plan Administrator or any Trustee listed above.
Type of Administration of Health Care Benefits Provided by the Plan & Plan Year	Trustees and Self-Administered. The Plan is administered directly by the Plan Administrator. The Plan’s healthcare benefits are funded directly by the Plan and are not insured by an outside entity. Each Plan-Year ends each year on December 31.

Section 11 Definitions of Important Words Used in This Benefit Guide (Evidence of Coverage)

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

Appeal – An appeal is a special kind of complaint you make if you disagree when you want a reconsideration or a change to a decision we have made about what Medicare Part D drugs are covered for you or what we will pay for a drug. Section 7 explains what appeals are, including the process involved in making an appeal.

Ascend Specialty Drug Pharmacy – A UPREHS preferred pharmacy that provides self-injectable medications that treat conditions such as Rheumatoid Arthritis, Multiple Sclerosis, Hepatitis-C, Cancer, Transplant and other conditions requiring self-injectable medications (excluding insulin).

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

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

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent the annual required amount in covered drugs during the covered year.

Cost sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered. UPREHS pays your annual deductible amount; (2) any fixed copayment amounts that a plan may require be paid when specific drugs are received; or (3) any coinsurance amount that must be paid as a percentage of the total amount paid for a drug.

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

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

Covered Drugs – The term we use to mean all of the prescription drugs covered by the UPREHS Medicare Prescription Drug Plan and Medicare Part D.

Creditable Coverage – Prescription drug coverage (for example, from an employer or union) that is at least as good as the standard Medicare Prescription Drug coverage.

Customer Services – A department responsible for answering your questions about your membership, benefits, grievances, and appeals. See the Introduction for information about how to contact UPREHS Customer Services or call 1-800-547-0421.

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

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

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

Exception – A type of coverage determination that, if approved, allows you to get a nonpreferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if our Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered Medicare Part D drugs provided by our Plan. UPREHS Prime Medicare Plan includes all Medicare Part D covered drugs on our formulary.

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

Grievance - A type of complaint you make concerning the quality of your care, about us, or one of our Plan providers. This type of complaint does not involve coverage or payment disputes. See Section 6 for more information about grievances.

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

Initial Coverage Stage – This is the period before your total drug expenses have reached \$2,840. This amount includes what you and/or others have paid and what our Plan has paid.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

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

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

Medically Necessary – Services that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

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

Medicare Advantage (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 (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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

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

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

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

Nonpreferred Network Retail Pharmacy – A retail pharmacy that offers covered drugs to members of our Plan at higher copayment levels than apply at the preferred Depot Drug Mail Pharmacy and Depot Drug Walk-In Pharmacies. Prescriptions filled at nonpreferred network retail pharmacies are limited to 30-day (or less) supplies.

Original Medicare Plan – (Traditional Medicare or Fee-for-service Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program. 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 we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Benefit Guide, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see Medicare Advantage (MA) Plan.

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

Part D Drugs – Drugs that Congress permits our Plan to offer as part of our Medicare Prescription Drug benefit. We offer all Part D drugs. See your formulary for a specific list. Congress specifically excludes certain categories of drugs, such as benzodiazepines and barbiturates from Part D. These drugs are not considered to be Part D drugs.

Preferred Network Pharmacy – The Depot Drug Mail Pharmacy, Depot Drug Walk-In Pharmacies and the Ascend Specialty Pharmacy provide covered drugs to members of our Plan at lower copayment levels than apply at nonpreferred network retail pharmacies. Preferred Depot Drug Pharmacies supply maintenance prescriptions and those drugs intended to be taken longer than 30 days.

Prior Authorization (or Preauthorization) – Approval in advance to get certain drugs such as all compounded drugs. Some services are covered only if your doctor or other plan provider gets prior authorization from us. Covered services that need prior authorization are marked in the formulary.

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

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan. The UPREHS Medicare Plans' service area is national.

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.



Medicare^{Rx}
Prescription Drug Coverage

PO Box 161020 / Salt Lake City, Utah 84116-1020 / Phone (800) 547-0421 / Fax (801) 595-4399