



2017 SUMMARY OF BENEFITS  
UNDERSTANDING OUR MEDICARE-APPROVED  
PRESCRIPTION DRUG PLAN (PDP)



# A PART D PRESCRIPTION DRUG PLAN (PDP) DESIGNED FOR YOU

## LOW MONTHLY PREMIUM: \$14.60



### DEDUCTIBLE

\$0 deductible on drug tiers 1 & 2  
(See next page for tier 3-5 deductibles)

### COPAYS AND COINSURANCE

INITIAL COVERAGE STAGE	Amount you pay until you and the plan pay a total of \$3,700 (includes deductible) for covered prescription drug expenses			
	30-day supply		90-day supply	
	Preferred Pharmacy	Standard Pharmacy	Preferred Pharmacy	Standard Pharmacy
Drug Coverage Tiers				
Tier 1 – Preferred Generic	\$1	\$14.90	\$3 (retail) \$2 (mail)	\$44.70
Tier 2 – Generic	\$15	\$20	\$45	\$60
Tier 3 – Preferred Brand	10%	20%	10%	20%
Tier 4 – Non-preferred Drug	Varies by state. See next page.			
Tier 5 – Specialty	27%	27%	Not covered	Not covered

The above are applicable for both retail and mail-order pharmacies. If you reside in a long-term care facility, you pay the same as at a standard pharmacy and may receive up to a 31-day supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

COVERAGE GAP STAGE	Amount of out-of-pocket costs you pay between \$3,701 and \$4,950 in total prescription drug expenses	
	30-day or 90-day supply	
Generic	You pay 51% of the cost	
Brand	You pay 40% of the negotiated price and a portion of the dispensing fee	

CATASTROPHIC STAGE	Amount you pay after \$4,950 in annual out-of-pocket covered prescription drug expenses	
	30-day or 90-day supply	
Generic	You pay the greater of 5% coinsurance or \$3.30 copay	
Brand	You pay the greater of 5% coinsurance or \$8.25 copay	

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request an Evidence of Coverage by calling Member Services or visit [envisionrxplus.com](http://envisionrxplus.com). Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

## TIER 3-5 DEDUCTIBLES AND TIER 4 COINSURANCE VARY BY STATE

State	Annual Deductible (Tier 3-5)	Preferred Pharmacy (30 or 90-day supply; Tier 4 only)	Standard Pharmacy (30 or 90-day supply; Tier 4 only)
Connecticut	\$260	25%	34%
Delaware	\$270	25%	39%
District of Columbia	\$270	25%	39%
Georgia	\$260	25%	36%
Maine	\$270	27%	42%
Maryland	\$270	25%	39%
Massachusetts	\$260	25%	34%
Michigan	\$270	25%	40%
New Hampshire	\$270	27%	42%
New York	\$270	25%	41%
North Carolina	\$260	25%	39%
Ohio	\$280	24%	32%
Oregon	\$270	25%	42%
Pennsylvania	\$260	25%	32%
Rhode Island	\$260	25%	34%
South Carolina	\$270	25%	35%
Vermont	\$260	25%	34%
Washington	\$270	25%	42%
West Virginia	\$260	25%	32%

The above coinsurance are applicable for both retail and mail-order pharmacies.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

This information is available for free in other languages. Please call our customer service number at 1-866-250-2005 (TTY: 711) 24 hours a day, 7 days a week. Esta información está disponible gratuitamente en otros idiomas. Llame a nuestro Cuidado al Cliente, al 1-866-250-2005 (teléfono de texto/TTY: 711), las 24 horas del día, los 7 días de la semana.

Other pharmacies are available in our network. The formulary and pharmacy network may change at any time. You will receive notice when necessary.

If you want to know more about the coverage and costs of Original Medicare or to compare plans, look in your current “Medicare & You” handbook. You can also view it online at <http://www.medicare.gov>. You can also call 1-800-MEDICARE to order your booklet.

You can see the complete plan formulary (list of Part D covered prescription drugs) and any restrictions, as well as view the pharmacy directory on our website at [envisionrxplus.com](http://envisionrxplus.com). EnvisionRxPlus is a PDP with a Medicare contract. Enrollment in EnvisionRxPlus depends on contract renewal.

If you qualify for Extra Help, you get help paying for any Medicare drug plan’s monthly premium, yearly deductible, and prescription coinsurance. This “Extra Help” also counts toward your out-of-pocket costs. People with limited income and resources may qualify for “Extra Help.” Some people automatically qualify for “Extra Help” and don’t need to apply. Medicare mails a letter to people who automatically qualify for “Extra Help.”

You may be able to get “Extra Help” to pay for your prescription drug premiums and costs. To see if you qualify for getting “Extra Help,” call:

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

EnvisionRxPlus complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EnvisionRxPlus does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. EnvisionRxPlus:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services. If you believe that EnvisionRxPlus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: EnvisionRxPlus, mailing address: 2181 E. Aurora Rd, Ste. 201, Twinsburg, OH, 44087, Member Services: 1-866-250-2005, TTY: 711, fax: 1-877-503-7231, email: [clinicalservices@envisionrxplus.com](mailto:clinicalservices@envisionrxplus.com). If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.