The 2021 Granite Alliance Insurance Company (PDP) Pharmacy Benefit Guide and Evidence of Coverage for DMBA Participants

Your Medicare Prescription Drug Coverage as a Participant in Granite Alliance Insurance Company

This Pharmacy Benefit Guide gives you the details about your Medicare prescription drug coverage from January 1 to December 31, 2021. This is also known as the Evidence of Coverage (EOC). It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

When this booklet refers to "we," "us," or "our," it is referencing Granite Alliance. When it refers to "plan" or "our plan," it is referencing the DMBA Prescription Drug Plan provided through Granite Alliance Insurance Company.

Benefits, premiums and/or copayments/coinsurance may change on January 1, 2022. The formulary and pharmacy network may change at any time. You will receive notice when necessary.

For help or additional information, please call Granite Alliance Member Services Team. We are available 24 hours a day, 7 days a week.

Toll-free 855-586-2573
TTY users call 711
www.mygraniterx.com

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Chapter 1. Getting Started

DMBA has contracted with Granite Alliance Insurance Company, a Medicare-approved Prescription Drug Plan (PDP), to provide your pharmacy benefits. The Granite Alliance Medicare Prescription Drug Plan is administered by Magellan Rx Management (the same company that administers the pharmacy benefits for DMBA's active plan members).

This booklet tells you how to get your prescription drug coverage through Granite Alliance, explains your rights and responsibilities, what is covered, and what you pay.

The terms "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of Granite Alliance Insurance Company.

If you are a new participant, it's important for you to learn what Granite Alliance's rules are and what coverage is available to you. We encourage you to set aside some time to look through this booklet.

If you are confused or concerned or just have a question, please contact Granite Alliance Member Services. (Phone numbers are printed on the back cover of this booklet.)

Legal information about the Pharmacy Benefit Guide/Evidence of Coverage

This Pharmacy Benefit Guide, also known as the *Evidence of Coverage* (EOC) along with other notices you may receive from us (sometimes called riders or amendments) is our contract with you. It explains your rights, benefits, and responsibilities as a member of Granite Alliance. It also explains our responsibilities to you.

This Benefit Guide gives you details about your prescription coverage, including:

- What is and what is not covered.
- How to get your prescriptions filled.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.

The contract is in effect for months in which you are enrolled in Granite Alliance Insurance Company between January 1, 2021 and December 31, 2021. Medicare must approve the Granite Alliance plan each year. You will always be notified before we change the costs or benefits.

What makes you eligible for coverage in a Medicare prescription drug plan?

You are eligible for membership in Granite Alliance as long as:

- you meet the requirements to receive retirement benefits through your former employer, which is sponsoring this benefit;
- you live in our geographic service area;
- you have Medicare Part A **and** Medicare Part B; and
- you are a United States citizen or are lawfully present in the United States

What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals for inpatient services, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Granite Alliance's Service Area

Although Medicare is a federal program, the Granite Alliance plan is available only to individuals who live in the Granite Alliance service area. To remain a member of Granite Alliance, you must continue to reside in Granite Alliance service area, which includes all 50 states, the District of Columbia, and Puerto Rico.

If you plan to move out of the service area, please contact Granite Alliance Member Services. (Phone numbers are printed on the back cover of this booklet.)

If you are leaving our service area, you are still eligible for prescription coverage through DMBA. Please make sure to coordinate with DMBA so that you do not experience any interruptions in your coverage.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in this booklet.

U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Granite Alliance if you are not eligible to remain a member on this basis. Granite Alliance must disenroll you if you do not meet this requirement.

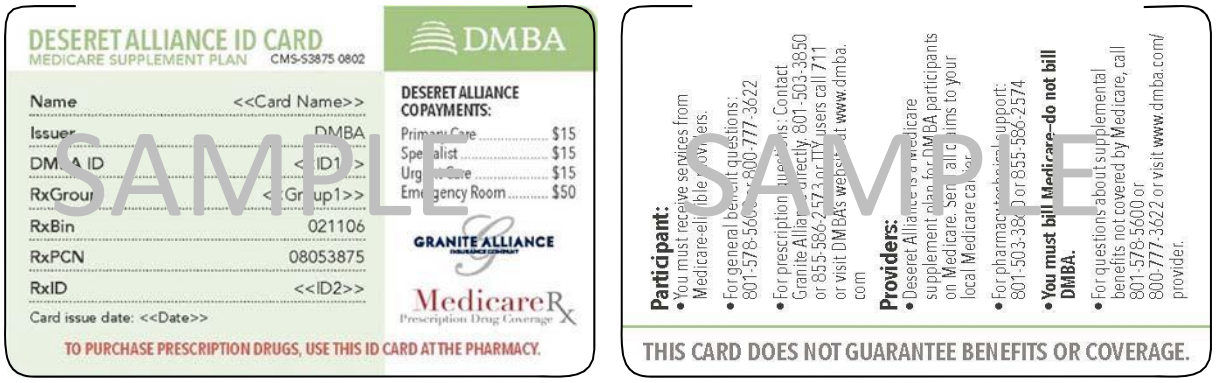
What other materials will you get from us?

Your Deseret Alliance/Granite Alliance member ID card—Use it to get prescription drugs and medical benefits.

While you are a member of Granite Alliance, you must use your Deseret Alliance/Granite Alliance member ID card at the pharmacy when purchasing prescription drugs. You will need to pay the pharmacy **your** share of the cost when you pick up your prescription.

Your member ID card also includes information regarding your medical benefits. To receive medical services, you must show your red, white, and blue Medicare card when visiting the doctor, emergency room, or other medical providers.

Here's a sample participant ID card:



Please carry your card with you at all times and remember to show your card when you get covered drugs or use your medical benefits. If your participant ID card is damaged, lost, or stolen, call Granite Alliance Member Services right away and we will send you a new card.

If you don't have your Deseret Alliance/Granite Alliance ID card with you when you fill your prescription, ask the pharmacy to call Granite Alliance to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. (You can then ask us to reimburse you for our share.)

The Pharmacy Directory: Your guide to pharmacies in our network

Granite Alliance has contracted with a network of pharmacies where you can fill your prescription drugs. Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. To be eligible for benefits, you must use a network pharmacy to fill your prescriptions. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. All major pharmacy chains and most retail pharmacies are participating in our network including VRx Pharmacy @ City Creek, CVS, Costco, Smith's Food and Drug, Harmons, Walmart, Fresh Market, Target, Walgreens and Sav-On pharmacies. You can find participating pharmacies by logging into your DMBA account at www.dmba.com. Select *Find a Provider* at the top of your home page, then *Find a participating pharmacy* under *Pharmacy*. You can also call us and we will send you a copy of the *Pharmacy Directory* or help you find a pharmacy you can go to.

Our *Pharmacy Directory* gives you a complete list of our network pharmacies—that means all pharmacies that have agreed to fill covered prescriptions for Granite Alliance members.

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want Granite Alliance to cover (help you pay for) them.

If you don't have the *Pharmacy Directory*, you can get a copy from Granite Alliance Member Services. (Phone numbers are printed on the back cover of this booklet.) At any time, you can call Granite Alliance Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information at www.dmba.com as explained previously.

The *List of Covered Drugs (Formulary)*

Granite Alliance has a *List of Covered Drugs (Formulary).* We call it the Drug List or *Formulary* for short. It tells which prescription drugs are covered by Granite Alliance. The drugs on this list are selected by Granite Alliance with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Granite Alliance Insurance Company Formulary.

The *Formulary* also tells you if there are any rules that restrict coverage for your drugs.

If you want a *Formulary* mailed to you, or you have questions regarding a covered medication, please call 855-586-2573. An online printable formulary will be available at www.mygraniterx.com on October 15. You may also email your request for a formulary to GAICHelp@magellanhealth.com.

To get the most complete and current information about which drugs are covered, you can log into your account at www.dmba.com, select *My*, then choose *Drug Formulary* under *Pharmacy (Granite Alliance).* You can also visit the Granite Alliance website (www.mygraniterx.com) or call Granite Alliance Member Services for additional help regarding drug coverage or to see if there are lower-cost alternatives. (Phone numbers are printed on the back cover of this booklet.)

The Pharmacy *Explanation of Benefits* (EOB)

When you use your prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your prescription drugs. This summary report is called the *Explanation of Benefits* (EOB).

The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options. An EOB summary is also available upon request. To get a copy, please contact Granite Alliance Member Services.

Many participants are required to pay other Medicare premiums

In addition to paying the monthly plan premium through DMBA, many participants are required to pay other Medicare premiums. Some plan participants (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan participants pay a premium for Medicare Part B.

For information about your plan premium, please contact DMBA.

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

- **If you are required to pay the extra amount and you do not pay it, you *will* be disenrolled from the Granite Alliance Prescription Drug Plan.**
- If you have to pay an extra amount, Social Security, not DMBA or Granite Alliance, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, visit www.medicare.gov or call 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048. Or you may call Social Security at 800-772-1213. TTY users should call 800-325-0778.

Your copy of the *Medicare & You 2021* handbook gives information about the Medicare premiums in the section called 2021 Medicare Costs. This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You* from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users call 877-486-2048.

How to help make sure that we have accurate information about you

Your membership record has information about you, including your address and telephone number, and your specific plan coverage.

The pharmacists in the Granite Alliance network need to have correct information about you. These network providers use your membership record to know what drugs are covered and the cost-sharing amounts for you. Because of this, it is very important that you help us keep your information up to date.

Let DMBA or Granite Alliance know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let DMBA know by calling Granite Alliance Member Services. (Phone numbers are printed on the back cover of this booklet.) It is also important to contact Social Security if you move or change your mailing address.

Read over the information we send you about any other insurance coverage you have

That's because we must coordinate any other coverage you have with your benefits through DMBA.

Please let Granite Alliance or DMBA know about any other coverage that you may have. Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Granite Alliance Member Services. (phone numbers are printed on the back cover of this booklet.)

How other insurance works

When you have other insurance, there are rules set by Medicare that determine whether Granite Alliance or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for DMBA retirees:

- If you have retiree coverage, Medicare pays first.
- If your Granite Alliance coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or end-stage renal disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, Granite Alliance pays first.
    - If you're over 65 and you or your spouse is still working, Granite Alliance pays first.
    - If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Granite Alliance Member Services. (Phone numbers are printed on the back cover of this booklet.) You may need to give your Granite Alliance ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Contact Information

Granite Alliance Contact Information

For assistance with pharmacy claims, billing, questions, grievances, appeals, or coverage determinations please call, write, or email Granite Alliance Member Services. We will be happy to help you.

Method	Granite Alliance Member Services—Contact Information
CALL	855-586-2573 Calls to this number are free. We are available 24 hours a day, 7 days a week. Granite Alliance Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are available 24 hours a day, 7 days a week.
FAX	888-656-8099
WRITE	Granite Alliance Insurance Company P.O. Box 1382 Maryland Heights, MO 63043
E-MAIL	GAICHelp@magellanhealth.com Email for general information, appeals or grievances/complaints
WEBSITE	Log into your DMBA account at www.dmba.com, select *My Health*, then *Pharmacy (Granite Alliance).* For general information visit the Granite Alliance website at www.mygraniterx.com

Medicare

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 (permanent kidney failure requiring dialysis or a kidney transplant).
The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Prescription Drug Plans, including Granite Alliance.

Method	Medicare—Contact Information
CALL	800-MEDICARE, or 800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	877-486-2048 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Granite Alliance Insurance Company: • **Tell Medicare about your complaint:** You can submit a complaint about Granite Alliance Insurance Company directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.)

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. The SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Call Medicare at 800-633-4227 to find the SHIP in your state. You can also visit Medicare's website at www.medicare.gov.

Quality Improvement Organizations (QIO)

The Quality Improvement Organization (QIO) is a group of doctors and other healthcare professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This is an independent organization. It is not connected with Granite Alliance. There is a QIO in each state. QIOs have different names, depending on which state they are in. You should contact your QIO if you have a complaint about the quality of care you have received. For example, you can call your QIO if you were given the wrong medication or if you were given medications that interacted in a negative way. You can find contact information of the QIO in your state by calling Medicare at 800-633-4227.

Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or end-stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their drug coverage because they have a higher income. If you received a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	800-772-1213 Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	800-325-0778 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Available 7 a.m. to 7 p.m. eastern time, Monday through Friday.
WEBSITE	www.ssa.gov

Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits [QMB+].)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits [SLMB+].)
    - Qualified Individual (QI): Helps pay Part B premiums.
    - Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

To find out more information about Medicaid and its programs, contact your state Medicaid Office.

Information about programs to help pay for prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and financial investments, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium and prescription copayments/coinsurance. The "Extra Help" also counts toward your annual out-of-pocket costs.

Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help. Others who do not automatically qualify may still be eligible after submitting an application.

To see if you qualify for getting Extra Help, call:

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

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, call Granite Alliance Member Services to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

When we receive the evidence showing your copayment level, we will update the system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. We will either forward a check to you in the amount of your overpayment or offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Granite Alliance Member Services if you have questions. (Phone numbers are printed on the back cover of this booklet.)

State Pharmaceutical Assistance Programs (SPAPs)

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its participants.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. Please contact the 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 800-633-4227.

Do you have other health insurance?

If you have other prescription drug coverage in addition to your DMBA sponsored plan, through your (or your spouse's) employer or retiree group, please contact that group's benefits administrator. The benefits administrator can help you determine how your current prescription drug coverage will work with Granite Alliance.

Chapter 3. Your Prescription Drug Coverage Rules

If you are in a program that helps pay for your drugs, **some information in this *Pharmacy Benefit Guide*/*Evidence of Coverage* about the costs for prescription drugs may not apply to you.** We will provide you with separate information, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the LIS Rider), which tells you about your drug coverage and copayments. If you don't have this insert, please call Granite Alliance Member Services and ask for the LIS Rider.

This chapter explains rules for using your coverage for prescription drugs. The next chapter tells what you pay for prescription drugs.

In addition to your coverage through DMBA, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* Handbook.) Your Part D prescription drugs are covered by Granite Alliance.

Basic rules for prescription drug coverage

Granite Alliance will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy, which includes mail order, to fill your prescription. A network pharmacy is a pharmacy that has a contract to provide covered prescription drugs on behalf of Granite Alliance. To find a network pharmacy, you can look in your *Pharmacy Directory,* call Granite Alliance Member Services, or log into www.dmba.com , select *Find a Provider* then *Find a participating pharmacy* under *Pharmacy.*
- Your drug must be on the *List of Covered Drugs (Formulary).* (We call it the Drug List for short.)

- Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain references.

Using the mail order benefit

Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The mail order service allows you to order up to a 90- day supply. To get order forms and information about filling your prescriptions by mail, call Granite Alliance Member Services or log into www.dmba.com, select *My Health*, then *Mail Order Prescriptions* under *Pharmacy (Granite Alliance*). You can find a participating pharmacy by selecting *Find a Provider* and *Find a participating pharmacy* under *Pharmacy*.

How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. Granite Alliance offers two ways to get a long-term supply of maintenance drugs. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies allow you to get a long-term supply of maintenance drugs. Your Pharmacy Directory tells you which pharmacies in the network can give you a long-term supply of maintenance drugs. You can also call Granite Alliance Member Services for more information.

2. You can also use mail-order services, which allows you to order up to a 90-day supply.

What happens when my doctor sends the prescription directly to the mail order?

The pharmacy will contact you each time it gets a new prescription from a healthcare provider to see if you want the medication filled and shipped immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time the pharmacy contacts you to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail order prescriptions. For refills, please contact our pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time and to the correct address.

Please make sure the pharmacy knows the best way to contact you and has your current contact information so they can reach you to confirm prescription orders.

Specialized Pharmacies

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Granite Alliance Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Granite Alliance Member Services. (Phone numbers are printed on the back cover of this booklet.)

When can you use a pharmacy that is not in the network?

Generally, we cover drugs filled at an out-of-network pharmacy **only** when you are not able to use a network pharmacy. In these situations, **please check first with Granite Alliance Member Services** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from Granite Alliance?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for Granite Alliance's share of the cost.

Your drugs need to be on the Drug List

Granite Alliance has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by Granite Alliance with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. In fact, Medicare reviews and approves the Granite Alliance Drug List every year.

The drugs on the Drug List are only those covered by Medicare.

We will generally cover a drug on the Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A medically accepted indication is a use of the drug that is either:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed); or
- supported by certain references and organizations including the *American Hospital Formulary Service Drug Information* and the *DRUGDEX Information System*.

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs. If you are taking a brand-name drug and would like to know if there is a generic alternative available for a lower cost, call the Granite Alliance Member Services team.

What is *not* on the Drug List?

Granite Alliance does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs.
- In other cases, we have decided not to include a particular drug on the Drug List.

Cost-sharing tiers for drugs on the Drug List

Every drug on the Drug List is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. To find out which cost-sharing tier your drug is in, look it up in the Drug List.

How can you find out if a specific drug is on the Drug List?

To find if your drug is covered you can:

1. Log into your account at www.dmba.com, select *My Health*, then *Drug Formulary* under *Pharmacy (Granite Alliance)*. The Drug List on the website is always the most current.
2. Call Granite Alliance Member Services to find out if a particular drug is on the Drug List or to ask for a copy of the drug list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

There are restrictions on coverage for some drugs

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our participants use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, the rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher- cost drug, Granite Alliance's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for a medication you take, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you.

Please note that sometimes a drug may appear more than once in the drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your healthcare provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Granite Alliance uses different types of restrictions to help participants use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand-name drugs when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. In most cases, **when a generic version of a brand-name drug is available, the network pharmacies will provide you the generic version.** We usually will not cover the brand-name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you or has written "No substitutions" on your prescription for a brand- name drug, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug and coverage decision process may apply for the brand-name drug.)

Getting approval in advance (prior authorization)

For certain drugs, you or your provider need to get approval from Granite Alliance before we will agree to cover the drug for you. This is called **"prior authorization"**. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If prior authorization is required and you do not get this approval, your drug might not be covered.

Trying a different drug first (step therapy)

This requirement encourages you to try less costly but just as effective drugs before Granite Alliance covers another drug. For example, if Drug A and Drug B treat the same medical condition, Granite Alliance may require you to try Drug A first. If Drug A does not work for you, Granite Alliance will then cover Drug B. This requirement to try a different drug first is called "**step therapy"**.

Quantity limits

For certain drugs, we limit the amount of the drug that will be covered by the plan. For example, Granite Alliance might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Do any of these restrictions apply to your drugs?

Granite Alliance's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Granite Alliance Member Services (phone numbers are printed on the back cover of this booklet) or log into your account at www.dmba.com

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Granite Alliance Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you.

What if one of your drugs is not covered in the way you'd like it to be?

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** Some of the drugs covered have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.

- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be?** Granite Alliance puts each covered drug into one of four (4) different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way you'd like it to be covered. Your options depend on what type of restriction your drug has.

What can you do if your drug is not on the Drug List or if the drug is restricted?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug. (Only participants in certain situations can get a temporary supply.) This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask Granite Alliance to cover the drug or remove restrictions from the drug.

You may be able to get a temporary/transition supply

Under certain circumstances, Granite Alliance can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is no longer on the Drug List.
- The drug you have been taking is now restricted in some way.

2. You must be in one of the situations described below:

- For participants who were in the plan last year and aren't in a long-term care (LTC) facility, we will cover a temporary supply of your drug during the first 90 days of the calendar year. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30-days of medication. The prescription must be filled at a network pharmacy.

- For participants who are new to the plan and aren't in a long-term care (LTC) facility, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan. This temporary supply will be for a maximum of a 30-day supply. If your

prescription is written for fewer days, we allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

- For participants who were in the plan last year and reside in a long-term care (LTC) facility, we will cover a temporary supply of your drug during the first 90 days of the calendar year. The total supply will be for a maximum of a 31-day supply of medication. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 31-day supply of medication as appropriate. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- For participants who are new to the plan and reside in a long-term care (LTC) facility, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan. The total supply will be for a maximum of a 31-day supply of medication. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 31-day supply of medication as appropriate. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- For participants who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away, we will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call Granite Alliance Member Services.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by Granite Alliance or ask Granite Alliance to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by Granite Alliance that might work just as well for you. You can call Granite Alliance Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask Granite Alliance to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask Granite Alliance to cover a drug even though it is not on the Drug List. Or you can ask Granite Alliance to make an exception and cover the drug without restrictions.

What can you do if your drug is in a tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Granite Alliance Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Granite Alliance Member Services are printed on the back cover of this booklet.)

You can ask for an exception

For drugs in tier 3, you and your provider can ask Granite Alliance to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

Drugs in some of the cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in tiers 1, 2, or 4.

What if your coverage changes for one of your drugs?

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, Granite Alliance might make changes to the Drug List. For example, Granite Alliance might:

- Add or remove drugs from the Drug List. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug.
- Replace a brand name drug with a generic drug**.**

In almost all cases, we must get approval from Medicare for changes we make to the Drug List.

What happens if coverage changes for a drug you are taking?

If there is a change to coverage for a drug you are taking, Granite Alliance will send you a notice to tell you. Normally, we will let you know at least 30 days ahead of time.

Once in a while, a drug is suddenly recalled because it's been found to be unsafe or for other reasons. If this happens, Granite Alliance will immediately remove the drug from the Drug List. Your provider should know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

In the following cases, you will be affected by the coverage changes during the current year:

A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)

- We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions.
- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug
- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 6 [What to do if you have a problem or complaint (coverage decisions, appeals, complaints]).
- If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

Unsafe drugs and other drugs on the Drug List that are withdrawn from the market

Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.

Your prescriber will also know about this change and can work with you to find another drug for your condition.

Other changes to drugs on the Drug List

We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.

After you receive notice of the change, you should be working with your prescriber to switch to a different drug that is on the Drug List.

Or you or your prescriber can ask us to make an exception and continue to cover the drug for you.

Changes to drugs on the Drug List that will not immediately affect people currently taking the drug:

For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List in the new benefit year for any changes to drugs.

What types of drugs are *not* covered?

This section tells you what kinds of prescription drugs are excluded. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation.

Here are some general rules about drugs that Medicare will not cover under Part D:

- A drug that would be covered under Medicare Part A or Part B.
- Drugs that are used off-label. "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.
    - Generally, coverage for off-label use is allowed only when the use is supported by certain references and organizations. These are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System. If the use is not supported by any of these references or organizations, then Granite Alliance cannot cover its "off-label use".

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- 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

If you receive Extra Help paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

Part D drug coverage in special situations

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, Granite Alliance will cover your drugs as long as the drugs meet all of the rules for coverage. See the previous parts of this chapter that describe the rules for getting drug coverage.

If you are admitted to a skilled nursing facility for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, Granite Alliance will cover your drugs as long as the drugs meet all of the rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

What if you’re a resident in a long-term care (LTC) facility?

Usually, an LTC facility, (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility’s pharmacy if it is part of the network.

Check your *Pharmacy Directory* to find out if your long-term care facility’s pharmacy is part of the network. If it isn’t, or if you need more information, please contact Granite Alliance Member Services. (Phone numbers are printed on the back cover of this booklet.)

What if you’re a resident in a long-term care (LTC) facility and become a new participant in Granite Alliance?

If you need a drug that is not on the Drug List or is restricted in some way, Granite Alliance will cover a **temporary supply** of your drug during the first 90 days of your membership. Refer to the transition information in this booklet for more information.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered that might work just as well for you. Or, you and your provider can ask Granite Alliance to make an exception for you and cover the drug in the way you would like it to be covered.

What if you are taking drugs covered by Original Medicare?

Your enrollment in Granite Alliance doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, Granite Alliance can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through Granite Alliance in other situations. But drugs are never covered by both Part B and Granite Alliance at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or Granite Alliance for the drug.

What if you are in a Medicare-certified Hospice?

Drugs are never covered by both hospice and Granite Alliance plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, Granite Alliance must receive notification from either the prescriber or your hospice provider that the drug is unrelated before Granite Alliance can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by Granite Alliance, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, Granite Alliance should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that describe the rules for getting drug coverage under Part D.

Programs on drug safety and managing medications

We conduct drug use reviews for participants to help make sure that they are getting safe and appropriate care. These reviews are especially important for participants who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems, such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug 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 provider to correct the problem.

Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use high-risk medications such as prescription opioids and benzodiazepines. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 6 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Medication Therapy Management (MTM) program to help members manage their medications

We have a prescription management program that can help participants 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.

This program is called our Medication Therapy Management Program (MTMP) and it is voluntary and free to participants. A team of pharmacists and doctors developed the program for us. This program can help make sure that participants are using the drugs that work best to treat their medical conditions and help us identify possible medication errors. Some participants who take several medications for different medical conditions may qualify.

A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, or any problems you're having. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "wellness Visit", so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other healthcare providers. Also, take your medication list with you if you go to the hospital or emergency room.

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 you from the program. If you have any questions about these programs, please contact Granite Alliance Member Services. (phone numbers are printed on the back cover of this booklet).

Chapter 4. What You Pay for Your Prescription Drugs

There are programs to help people with limited resources pay for their drugs. These include Medicare Extra Help and State Pharmaceutical Assistance Programs.

If you are in a program that helps pay for your drugs, some information in this booklet about the costs for Part D prescription drugs may not apply to you. If you qualify for assistance, we have included a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the LIS Rider), which tells you about your drug coverage. If you qualify for Medicare's Extra Help and did not receive this insert, please call Granite Alliance Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

Introduction

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use drug in this chapter to mean a covered prescription drug. Not all drugs are covered under your pharmacy benefit—some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- The *List of Covered Drugs (Formulary).* To keep things simple, we call this the Drug List.
    - This Drug List tells which drugs are covered for you.
    - It also tells which of the four (4) cost-sharing tiers the drug is in and whether there are any restrictions on your coverage for the drug.
    - If you need a copy of the Drug List, call Granite Alliance Member Services. You can also find the Drug List at www.dmba.com. After logging in, select *My Health*, then *Drug Formulary* under *Pharmacy (Granite Alliance)*. The Drug List on the website is always the most current.
- The Evidence of Coverage gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs.
- The Pharmacy Directory. In most situations you must use a network pharmacy to get your covered drugs. The Pharmacy Directory has a list of pharmacies in Granite Alliance's network. It also tells you which pharmacies in the network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

What you pay for a drug depends on which stage you are in

As shown in the table below, there are drug payment stages for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1 Initial Coverage Stage	**Stage 2** Coverage Gap Stage	**Stage 3** Catastrophic Coverage Stage
You begin in this stage when you fill your first prescription of the year. During this stage, Granite Alliance pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach $4,130.	During this stage, Granite Alliance will pay the same unless you are taking Tier 3 medications (see table on page 36. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach $6,550.	During this stage, Granite Alliance will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2021).

Your monthly Part D Explanation of Benefits (EOB)

Granite Alliance keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. Granite Alliance will prepare a written report called the *Explanation of Benefits* (EOB) when you have had one or more prescriptions filled during the previous month. It includes:

- **Prescription drug information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what Granite Alliance paid, and what you and others on your behalf paid.
- **Prescription drug cost totals for the year (since January 1).** This is called year-to-date information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display cumulative percentage increases for each prescription claim.
- **Available lower cost alternative prescriptions.** This will include information about other drugs with lower cost sharing for each prescription claim that may be available.

Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your Deseret Alliance membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of Granite Alliance's benefit
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Granite Alliance Member Services (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

The Initial Coverage Stage

During the Initial Coverage Stage, Granite Alliance pays its share of the cost of your covered prescription drugs, and you pay your share (your coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Cost-Sharing Tiers

Every drug on the Drug List is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug. To find out which cost-sharing tier your drug is in, look it up in the Drug List.

As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay **either** the full price of the drug **or** the copayment amount, **whichever is lower**.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations.

Prescription Category	From your local retail pharmacy, long-term care (LTC) pharmacy, and out-of- network pharmacies (limited to certain situations) for a 30-day supply, you'll pay:	From mail-order pharmacy and retail pharmacy for a 90-day supply, you'll pay:
TIER 1: Preferred Generic Medications	25% (or at least $5)	25% (or at least $10 but no more than $225)
TIER 2: Preferred Brand Medications	25% (or at least $5)	25% (or at least $10 but no more than $225)
TIER 3: Non-Preferred Medications	50% (or at least $5)	50% (or at least $10)
TIER 4: Specialty Medications	25% (at least $150, but no more than $225)	Not covered
Part D diabetic supplies (syringes, needles, and supplies)	10%	10%
Covered Immunizations	$0	N/A

What if you get less than a full month's supply?

There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects).

- If you are responsible for a coinsurance, you pay a **percentage** of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, so the **amount** you pay will be less.
- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug you receive. We will calculate the amount you pay per day for the drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you receive.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill date for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend on the supply you receive.

You stay in the Initial Coverage Stage until your total out-of-pocket costs in calendar year 2021 reach $4,130.

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and Granite Alliance, as well as any third parties, have spent on your behalf during the year. Many people do not reach the $6,550 limit in a year. If you do reach this amount, you will leave the Initial Coverage Stage and Coverage Gap Stage, and move on to the Catastrophic Coverage Stage.

How Medicare calculates your out-of-pocket costs for prescription drugs

Medicare has rules about what counts and what does **not** count as your out-of-pocket costs. When you reach the out-of-pocket limit of $6,550, you leave the Initial Coverage Stage and Coverage Gap Stage, and move on to the Catastrophic Coverage Stage.

When you add up your out-of-pocket costs, you can include the amount you pay for drugs when you are in the Initial Coverage Stage (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in this booklet):

- If you make these payments yourself, they are included in your out-of-pocket costs.

- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's Extra Help Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $6,550 in out-of-pocket costs within the 2021 calendar year, you will move from the Initial Coverage Stage and the Coverage Gap Stage, and move on to the Catastrophic Coverage Stage. This annual out-of-pocket amount is determined by Medicare each year.

These payments are *not* included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not** allowed to include any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by Granite Alliance
- Drugs you get at an out-of-network pharmacy that do not meet Granite Alliance's requirements
- Drugs not covered under your pharmacy benefit by Medicare, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Prescription drugs covered by Part A or Part B

- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan
- Payments for your drugs made by group health plans including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, workers' compensation)

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell Granite Alliance. Call Granite Alliance Member Services to let us know.

Coverage Gap Stage

You qualify for the Coverage Gap Stage when your out-of-pocket costs have reached the $4,130 limit for the 2021 calendar year. Once you are in the Coverage Gap Stage, you will stay in this payment stage until your out-of-pocket costs have reached $6,550 limit for the 2021 calendar year.

During this stage, Granite Alliance will pay the same unless you are taking Tier 3 medications. Tier 3 medications have a *better* benefit in this stage. As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in.

Prescription Category	From your local retail pharmacy, long-term care (LTC) pharmacy, and out-of-network pharmacies (limited to certain situations) for a 30-day supply, you'll pay:	From mail-order pharmacy and retail pharmacy for a 90-day supply, you'll pay:
TIER 1: Preferred Generic Medications	25% (or at least $5)	25% (or at least $10 but no more than $225)
TIER 2: Preferred Brand Medications	25% (or at least $5)	25% (or at least $10 but no more than $225)
TIER 3: Non-Preferred Medications (Generic and Brand)	25% (or at least $5)	25% (or at least $10)
TIER 4: Specialty Medications	25% (at least $150, but no more than $225)	Not covered
Part D diabetic supplies (syringes, needles, and supplies)	10%	10%
Covered Immunizations	$0	N/A

Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $6,550 limit for the 2021 calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, Granite Alliance will pay most of the cost for your drugs. As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in.

Prescription Category	From your local retail pharmacy, long-term care (LTC) pharmacy, and out-of-network pharmacies (limited to certain situations) for a 30-day supply, you'll pay:	From mail-order pharmacy and retail pharmacy for a 90-day supply, you'll pay:
TIER 1: Preferred Generic Medications	5% (or at least $3.70)	5% (or at least $3.70 but no more than $225)
TIER 2: Preferred Brand Medications	5% (or at least $9.20)	5% (or at least $9.20 but no more than $225)
TIER 3: Non-Preferred Medications (Generic and Brand)	5% (or at least $3.70 for generic and $9.20 for brand)	5% (or at least $3.70 for generic and $9.20 for brand)
TIER 4: Specialty Medications	5% (at least $9.20, but no more than $225)	Not covered
Part D diabetic supplies (syringes, needles, and supplies)	5% (or at least $3.70 for generic and $9.20 for brand)	5% (or at least $3.70 for generic and $9.20 for brand)
Covered Immunizations	$0	N/A

DMBA Vaccine Coverage

Granite Alliance provides coverage of a number of Part D vaccines. There are two parts to the coverage of vaccinations:

- The first part of coverage is the cost of the vaccine medication itself. The vaccine is a prescription medication.
- The second part of coverage is for the cost of giving you the vaccination shot. (This is sometimes called the administration of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are covered under your pharmacy benefit. You can find these vaccines listed in the *List of Covered Drugs (Formulary).*
    - Other vaccines are considered medical benefits. They are covered under Original Medicare.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination?**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask Granite Alliance to pay you back for the plan's share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your coinsurance for the vaccine and the cost of giving you the vaccination shot.
- Granite Alliance will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask Granite Alliance to pay the plan's share of the cost by using the procedures that are described in this booklet.
- You will be reimbursed the amount you paid less your normal coinsurance for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You pay the pharmacy the amount of your copayment for the vaccine.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask Granite Alliance to pay the plan's share of the cost.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay.

You may want to call us before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first whenever you are planning to get a vaccination. We can tell you about how your vaccination is covered and explain your share of the cost.

- We can tell you how to keep your cost down by using pharmacies in the network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from Granite Alliance for the plan's share of the cost.

Income Related Monthly Adjustment Amount (IRMAA)

Most people pay a standard monthly Part D premium. Because all of your benefits are provided through DMBA, your monthly Part D premium is included in (part of) your Deseret Alliance monthly premium. However, some people pay an extra amount because of their yearly income. If you have to pay an extra amount, Social Security, not DMBA/Granite Alliance, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security check unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.

How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out how to do this, contact Social Security at 800-772-1213 (TTY 800-325-0778).

The extra amount is paid directly to the government (not DMBA or Granite Alliance) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will not be eligible for coverage in a Medicare Part D plan.

Asking us to pay our share of the costs for covered drugs
When you should ask for reimbursement

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of Granite Alliance. In either case, you can ask for reimbursement.

Here are examples of situations in which you may need to ask for reimbursement. All of these examples are types of coverage decisions.

1. **When you use an out-of-network pharmacy to get a prescription filled**

   If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations.) Save your receipt and send a copy to us when you ask us for reimbursement.

2. **When you pay the full cost for a prescription because you don't have your plan membership card with you**

   If you do not have your Deseret Alliance/Granite Alliance membership card with you, you can ask the pharmacy to call Granite Alliance or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask for reimbursement.

3. **When you pay the full cost for a prescription in other situations**

   You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

   - For example, the drug may not be on the *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
   - Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to reimburse you.

4. **If you are retroactively enrolled.**

   Sometimes a person's enrollment is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

   If you were retroactively enrolled in and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask for reimbursement. You will need to submit paperwork for us to handle the reimbursement. Please call Granite Alliance Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. This booklet has information about how to make an appeal.

How to ask us to pay you back

Send your request for payment to Granite Alliance, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out the claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.mygraniterx.com) or call Granite Alliance Member Services and ask for the form.

Fax your request for payment together with any receipts to 888-656-8099 or mail them to:

Granite Alliance
Attention: Claims Department
P.O Box 1382
Maryland Heights, MO 63043

You must submit your claim to us within three years of the date you received the service, item, or drug.

Contact Granite Alliance Member Services if you have any questions. If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

We will consider your request for payment and say yes or no

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will reimburse you. We will mail your reimbursement to you within 30 days after your request was received.
- If we decide that the drug is **not** covered, or you did **not** follow all the rules, we will not reimburse you. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading the information in this booklet.

Chapter 5. Your Rights and Responsibilities

We must honor your rights

You have certain rights to help protect you. In this section we explain your Medicare rights and protections. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. We will also tell you about your responsibilities as a participant. If you want Medicare publications on your rights, you may call and request them at 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048. You can call 24 hours a day, 7 days a week.

Alternative Formats

We must provide information in a way that works for you (in languages other than English, braille, large print, or other alternate formats, etc.)

Granite Alliance has free language interpreter services available to answer questions from non-English-speaking participants. We can also give you information in braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about benefits in a format that is accessible and appropriate for you.

To get information from us in a way that works for you, please call Granite Alliance Member Services. (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information in a format that is accessible and appropriate for you, please file a grievance with Granite Alliance. You may also file a complaint with Medicare by calling 800-MEDICARE (800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Granite Alliance Member Services for additional information.

We must treat you with fairness and respect at all times

Granite Alliance must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights 800-368-1019 (TTY 800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Granite Alliance Member Services. If you have a complaint, such as a problem with wheelchair access, Granite Alliance Member Services can help.

We must ensure that you get timely access to your covered drugs

You have the right to get your prescriptions filled or refilled at any of the network pharmacies without long delays. If you think that you are not getting your covered drugs within a reasonable amount of time, you can contact Granite Alliance Member Services for personal help.

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, which tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a participant of a Medicare prescription drug plan, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at Granite Alliance, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Granite Alliance Member Services. (Phone numbers are printed on the back cover of this booklet.)

Your right to get information

You have the right to get several kinds of information from us. If you want any of the following kinds of information, please call Granite Alliance Member Services or log into your DMBA account at www.dmba.com, select *My Health*, then *Pharmacy (Granite Alliance)*.

- **Information about Granite Alliance**. This includes, for example, information about the number of appeals made by participants and Granite Alliance's performance ratings, including how it has been rated by plan participants and how it compares to other Medicare prescription drug plans.
- **Information about Granite Alliance network pharmacies**. For example, you have the right to get information from us about the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage**. To get the details on your Part D prescription drug coverage, read this booklet. If you have questions about the rules or restrictions, please call Granite Alliance Member Services.
- **Information about why something is not covered and what you can do about it.**
    - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
    - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal.
    - You can ask for reimbursement.

We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. Sometimes people become unable to make healthcare decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents you can use in these situations to give your directions in advance are called advance directives. There are different types of advance directives and different names for them. Documents called living will and power of attorney for healthcare are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get a form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state Department of Health.

You have the right to make complaints and to ask us to reconsider decisions we have made

You might need to ask Granite Alliance to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint**—we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other participants have filed against Granite Alliance in the past. To get this information, please call Granite Alliance Member Services.

What can you do if you believe you are being treated unfairly or your rights are not being respected?

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 800-368-1019 or TTY 800-537-7697, or call your local Office for Civil Rights.

If you believe you have been treated unfairly or your rights have not been respected, **and** it's **not** about discrimination, you can get help dealing with the problem you are having by calling:

- Granite Alliance Member Services
- Your State Health Insurance Assistance Program
- Medicare at 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

How to get more information about your rights

There are several places where you can get more information about your rights:

- Granite Alliance Member Services
- Your State Health Insurance Assistance Program
- Medicare:
    - You can visit the Medicare website to read or download the publication *Your Medicare Rights & Protections.* (The publication is available at: www.medicare.gov/Pubs/pdf/11534.pdf)
    - Or, you can call 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

You have some responsibilities as a participant

Along with the rights you have, 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 booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
- **If you have any other prescription drug coverage in addition to DMBA, you are required to tell us.** Please call Granite Alliance Member 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. This is called coordination of benefits because it involves coordinating the drug benefits

you get from Granite Alliance with any other drug benefits available to you. We'll help you coordinate your benefits.

- **Tell your pharmacist to bill Granite Alliance.** Show your Deseret Alliance/Granite Alliance ID card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help your doctors and other healthcare providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other healthcare providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Pay what you owe.** As a plan participant, you are responsible for these payments:
    - For most of your drugs covered by Granite Alliance, you must pay your share of the cost when you get the drug.
    - If you get any drugs that are not covered by Granite Alliance or by other insurance you may have, you must pay the full cost. If you disagree with our decision to deny coverage for a drug, you can make an appeal.
    - If you are required to pay a Part D late enrollment penalty, you must pay the penalty to remain a participant.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a participant.
- **Tell us if you move.** If you are going to move, it's important to tell us right away.
- **Call Granite Alliance Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving Granite Alliance.

Chapter 6. What to Do If You Have a Problem or Complaint

Coverage Decisions, Appeals, and Complaints

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the process for coverage decisions and appeals.
- For other types of problems, you need to use the process for making complaints.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance”, “coverage decision” rather than “coverage determination” or “at-risk determination”, and “Independent Review Organization” instead of “Independent Review Entity”. It also uses abbreviations as little as possible.

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do. The services of SHIP counselors are free.

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- Call 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

- Visit the Medicare website (www.medicare.gov).

How to get started

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, *A guide to the basics of coverage decisions and appeals*.

No. My problem is **not** about benefits or coverage.

Skip ahead to the end of this chapter: *How to make a complaint about quality of care, waiting times, customer service or other concerns*.

A guide to the basics of coverage decisions and appeals

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call Granite Alliance Member Services**. (Phone numbers are printed on the back cover of this booklet.)
- To **get free help from an independent organization** that is not connected with Granite Alliance, contact your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you**. For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf**. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Granite Alliance Member Services (phone numbers are printed on the back cover of this booklet) and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) You can also access the form at www.dmba.com. After logging in, select *My Health* then *Pharmacy Information* under *Pharmacy (Granite Alliance*), then *Go to Granite Alliance*. From there, select *Forms & Links* and choose *Printable Appointment of Representative Form.* The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf.

The form expires one year from the date signed, so this will need to be renewed annually. You must give us a copy of the signed form each year.

- **You also have the right to hire a lawyer to act for you**. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

How to ask for a coverage decision or make an appeal

Have you read the previous section (*A guide to the basics of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Your benefits as a member of the Granite Alliance plan include coverage for many prescription drugs. Please refer to the *List of Covered Drugs (Formulary).* To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references and organizations.)

- **This section is about drugs covered under your Part D pharmacy benefit only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by covered drugs, refer to the *List of Covered Drugs (Formulary),* rules and restrictions on coverage, and cost information.

Part D coverage decisions and appeals

As discussed earlier in this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Term	An initial coverage decision about your drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)

- *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
If you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. (This is a type of coverage decision.)
If you want us to cover a drug on the Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a coverage decision.
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.)
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.)

What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an *exception*. An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on the *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

Legal Term	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to tier 3: Non-Preferred Drug. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on the *List of Covered Drugs (Formulary).*

Legal Term	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the Drug List is in one of four (4) cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Term	Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If your drug is in tier 3 you can ask us to cover it at the cost-sharing amount that applies to drugs in tier 2 or tier 1, as applicable. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing for any drug in tiers 1, 2, or 4.

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, the Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception. If you ask us for a tiering exception, we will generally **not** approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal.

How to ask for a coverage decision, including an exception

Step 1:

You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a fast coverage decision. You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website (www.mygraniterx.com).
- **You or your doctor or someone else who is authorized to act on your behalf** can ask for a coverage decision.
- **If you want to ask us to pay you back for a drug,** start by reading the information in this booklet: How to ask us to pay you back. It also tells how to send us the paperwork that asks us to pay you back for the plan's share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a

written statement if necessary.

- **We must accept any written request,** including a request submitted on the CMS *Model Coverage Determination Request Form* or on Granite Alliance's form, which is available on our website (www.mygraniterx.com).

If your health requires it, ask us to give you a "fast coverage decision"

Legal Term	A "fast coverage decision" is called an **"expedited coverage determination."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision", we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a fast complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals.)

Step 2:

We consider your request and we give you our answer.

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer within 24 hours.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization.
- **If our answer is yes to part or all of what you requested**
  - If we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to

Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3:

If we say no to your coverage request, you decide if you want to make an appeal

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made.

How to make a Level 1 Appeal (how to ask for a review of a coverage decision)

Legal Term	An appeal to Granite Alliance about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1:

You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
- **Make your appeal by submitting a written request or calling us directly.**
- **We must accept any written request,** including a request submitted on the CMS *Model Coverage Determination Request Form*, which is available on our website (www.mygraniterx.com).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**

- You have the right to ask us for a copy of the information regarding your appeal.
- If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Term	A "fast appeal" is also called an **"expedited redetermination."**

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal".
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision."

Step 2:

We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for fast appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this

section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3:

If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Term	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1:

To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file". **You have the right to ask us for a copy of your case file.**

We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2:

The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested**, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal **within 14 calendar days** after it receives your request.
- **If the Independent Review Organization says yes to part or all of what you requested**
- If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3:

If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge.

Taking your appeal to Level 3 and beyond

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge who works for the federal government will review your appeal and give you an answer. **This judge is called an Administrative Law Judge.**

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Administrative Law Judge within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

- **If the Administrative Law Judge says no to your appeal, the appeals process *may or may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

How to make a complaint about quality of care, waiting times, customer service, or other concerns

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

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.

Complaint	Example
Quality of care	• Are you unhappy with the quality of the care you have received?
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 or poor customer service	• Has someone been rude or disrespectful to you? • Are you unhappy with how Granite Alliance has treated you?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by Granite Alliance Member Services or other staff at Granite Alliance? o Examples include waiting too long on the phone or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the **timeliness** of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs and you don't think we are meeting deadlines that apply. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Filing a Complaint

Legal Terms	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.**

Step 1:

Contact us promptly, either by phone or in writing.

Usually, calling Granite Alliance Member Services is the first step. If there is anything else you need to do, Granite Alliance Member Services will let you know. You can reach Granite Alliance Member Services toll-free at 855-586-2573; TTY users call 711. We are available 24 hours a day, 7 days a week.

If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

Whether you call or write, you should contact Granite Alliance Member 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 coverage decision* or a *fast appeal*, we will automatically consider your complaint a *fast* complaint. If you have a *fast* complaint, it means we will give you an answer within 24 hours.

Legal Terms	A **fast complaint** is also called an **expedited grievance.**

Step 2:

We look into your complaint and give you our answer.

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

- Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- If we do not agree with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Quality of care complaints: You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received by using the step-by- step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization (QIO).** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

You can also tell Medicare about your complaint

You can submit a complaint about Granite Alliance directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel Granite Alliance is not addressing your issue, please call 800-MEDICARE (800-633-4227). TTY users can call 877-486-2048.

Chapter 7. Eligibility for Medicare Part D

You are *not* eligible for pharmacy coverage by Medicare if any of the following happens:

- You do not stay continuously enrolled in Medicare Part A or Part B (or both)
- You become incarcerated (go to prison)
- You are not a United States citizen or lawfully present in the United States
- You lie about or withhold information about other insurance you have that provides prescription drug coverage
- You intentionally give us incorrect information when you are enrolling and that information affects your eligibility. (We cannot make you leave for this reason unless we get permission from Medicare first.)
- You continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other participants. (We cannot make you leave for this reason unless we get permission from Medicare first.)
- You let someone else use your membership card to get prescription drugs. (We cannot make you leave for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- You are required to pay the extra Part D amount because of your income and you do not pay it. Medicare **will** disenroll you and you will lose prescription drug coverage.

If you no longer wish to be covered by Granite Alliance, you may voluntarily (by your own choice) end your plan enrollment. If you choose to end your coverage with Granite Alliance, you will lose both medical and prescription coverage through DMBA and will not be able to re-enroll later. There are only certain times of the year, or certain situations, when you may voluntarily end your membership in the prescription drug plan. You may end your membership during the Annual Enrollment Period which occurs every November 1 through November 30 or during a Special Enrollment Period.

The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. To find out if you are eligible for a Special Enrollment Period, please call Medicare at 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users call 877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. 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.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

- A Medicare health plan. A Medicare health 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 health plans also include Part D prescription drug coverage.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may need to pay a Part D late enrollment penalty. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

If you choose to end your coverage with Granite Alliance, please be advised that this will end your medical *and* pharmacy coverage through DMBA and you will NOT be able to re-enroll later.

If you choose to end your coverage through DMBA and Granite Alliance, you can make a request in writing to us or you can contact Medicare at 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048

We *cannot* ask you to leave for health related reasons

Granite Alliance is not allowed to ask you to leave for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave because of a health-related reason, you should call Medicare at 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048. You may call 24 hours a day, 7 days a week.

You have the right to make a complaint if we end your membership

If we end your membership, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership.

Chapter 8. Legal Notices

Notice about governing law

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

Notice about non-discrimination

We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare prescription drug plans, such as Granite Alliance, 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.

Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Granite Alliance Insurance Company, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state law.

Chapter 9. Definitions of Important Words

Appeal: An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive.

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

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $6,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers Medicare.

Coinsurance: An amount you may be required to pay as your share of the cost for prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Complaint: The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Copayment (or "copay"): An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-Sharing: Cost-sharing refers to amounts that a participant has to pay when drugs are received. Cost-sharing includes any combination of the following types of payments: (1) any fixed copayment amount that is required when a specific drug is received; or (2) any coinsurance amount, a percentage of the total amount paid for a drug that is required when a specific drug is received. A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay.

Cost-Sharing Tier: Every drug on the list of covered drugs is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination: A decision about whether a drug prescribed for you is covered by 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, that isn't a coverage determination. You need to call or write to Granite Alliance to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this booklet.

Coverage Gap Stage: This is the stage when your out-of-pocket costs have reached the $4,130 limit for the 2021 calendar year. Once you are in the Coverage Gap Stage, you will stay in this payment stage until your out-of-pocket costs have reached $6,550 limit for the 2021 calendar year.

Covered Drugs: The term we use to mean all of the prescription drugs covered under your pharmacy benefit.

Creditable Prescription Drug Coverage: Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Disenroll or **Disenrollment:** The process of ending your membership. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee: A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Emergency: A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information: This document, along with your 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 have coverage under Granite Alliance.

Exception: A type of coverage decision that, if approved, allows you to get a drug that is not on the formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if you are required you to try another drug before receiving the drug you are requesting, or there are limits on the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug: A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance: A type of complaint you make about us or one of the network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Income Related Monthly Adjustment Amount (IRMAA): If your modified adjusted gross

income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage: This is the stage before your out-of-pocket costs for the year have reached $4,130 for the 2021 calendar year.

Part D Late Enrollment Penalty: An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the Part D late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a Part D late enrollment penalty.

List of Covered Drugs (Formulary or Drug List): A list of prescription drugs covered by Granite Alliance. The drugs on this list are selected by Granite Alliance with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy (LIS): See *Extra Help*.

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

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

Medicare Coverage Gap Discount Program: A program that provides discounts on most covered Part D brand name drugs to Part D members 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-Covered Services: Services covered by Medicare Part A and Part B.

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

"Medigap" (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member Services: A department within Granite Alliance responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy: A network pharmacy is a pharmacy where members of Granite Alliance can get their prescription drug benefits. We call them network pharmacies because they contract to fill prescriptions for Granite Alliance. In most cases, your prescriptions are covered only if they are filled at one of the network pharmacies.

Original Medicare (Traditional Medicare or Fee-for-service Medicare): Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital, or other healthcare provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy: A pharmacy that doesn't have a contract to fill prescriptions for Granite Alliance. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by Granite Alliance unless certain conditions apply.

Out-of-Pocket Costs: See the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's out-of-pocket cost requirement.

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

Part D Drugs: Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs

Participant: A person with Medicare who is eligible to get covered services through Granite Alliance and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Premium: The periodic payment to Medicare, an insurance company, or a healthcare plan for health or prescription drug coverage.

Prior Authorization: Approval in advance to get certain drugs that may or may not be on the formulary. Some drugs are covered only if your doctor or other network provider gets prior authorization from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO): A group of practicing doctors and other healthcare experts paid by the federal government to check and improve the care given to Medicare patients.

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.

Step Therapy: A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Service Area: A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period: A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security 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.

Granite Alliance Member Services

Method	Contact Information
CALL	Toll-free 855-586-2573. Calls to this number are free. We are available 24 hours a day, 7 days a week. Granite Alliance Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are available 24 hours a day, 7 days a week.
FAX	888-656-8099
WRITE	Granite Alliance P.O. Box 1382 Maryland Heights, MO 63043
EMAIL	GAICHelp@magellanhealth.com
WEBSITE	www.mygraniterx.com

GRANITE ALLIANCE
INSURANCE COMPANY