AFL HOTEL AND RESTAURANT WORKERS TRUST FUNDS

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HEALTH & WELFARE • PENSION • TRAINING

December 20, 2005

TO: **All Retired Participants and their Spouses eligible for Medicare residing outside of the State of Hawaii**
AFL Hotel and Restaurant Workers Health & Welfare Trust Fund

Participant Notice file (Hotel)

FROM: Board of Trustees

SUBJECT: **Medicare Prescription Drug (Part D) Coverage**

Effective January 1, 2006, in order to continue receiving prescription drug benefits through the Trust Fund's Indemnity Prescription Drug Plan you and your spouse, (if he or she is eligible for Medicare), **must enroll** in an **approved** Medicare Prescription Drug plan **offered in the state in which you reside**.

When you are covered under an approved Medicare Prescription Drug plan, the Trust Fund will then provide the following to you and your spouse, if he or she is eligible for Medicare:

A. MEDICARE PART D REIMBURSEMENT:

The Trust Fund will reimburse you for each Medicare beneficiary's Medicare Prescription Drug Plan premium, the **lesser** of your premium **or** $22.46 per month during calendar year 2006. You will be reimbursed on a quarterly basis.

In order for you to receive this reimbursement, you must submit the following documentation to the Trust Fund office:

1. A copy or description of the approved Medicare Prescription Drug Plan in which you are enrolled.

2. Confirmation of your enrollment in the Medicare Prescription Drug plan and your monthly premium payments.

Important Note: If you do not provide all required documentation, the Trust Fund will not make any reimbursement payment to you.

If you have questions on how to file for your quarterly Medicare Drug Plan premium reimbursement, contact the Trust Fund office at (808) 523-0199 or toll-free at 1-866-528-9677.

B. SUPPLEMENTAL PRESCRIPTION DRUG BENEFIT

After you have used your approved Medicare Prescription Drug plan, the Trust Fund will then provide a supplemental prescription drug benefit. In order to receive this benefit, you **must** do the following:

1. First, use your approved Medicare Prescription Drug plan, as directed, to obtain a covered prescription drug. You are responsible for paying any deductible and/or member copayment as indicated by your Medicare Prescription Drug plan.

2. Your Medicare Prescription Drug plan will provide you with an Explanation of Benefits for each covered prescription drug.

3. Mail a copy of your Medicare Drug Plan's Explanation of Benefits report, along with a completed claim form (enclosed) to the following address:

   R/X^{x} Pharmacy Solutions, Inc.
   Prescription Direct Reimbursement
   P.O. Box 135005
   Honolulu, HI 96801-5005
   Toll-Free Phone Number: 1 (866) 377-3977

4. You will be reimbursed for your Medicare Drug Plan's deductible and/or copayments that exceed the following:

Retail Pharmacy (up to a 30 day supply)

Generic Drugs	$ 7.00 per prescription
Brand Name Preferred	$15.00 per prescription
Brand Name Non-Preferred	$30.00 per prescription

Mail Order (up to a 90 day supply)

Generic Drugs	$10.00 per prescription
Brand Name Preferred	$30.00 per prescription
Brand Name Non-Preferred	$60.00 per prescription

If you have any questions or need assistance, please contact HMA, Inc. or R/X^{x} Pharmacy Solutions at (808) 951-4621 or toll free at 1 (866) 377-3977.

R/x^x Pharmacy Solutions, Inc.

PO Box 135005
Honolulu, HI 96801-5005
Visit our website rxxpbm.com
Pharmacy Services (808) 951-4621
Toll Free Phcy Services (866) 377-3977

Medicare Part D Supplemental Claim Form

*****MEDICARE PART D REPORT MUST BE ATTACHED FOR PROCESSING*****

PART A	***Subscriber: Please complete all Part A areas***
Print Subscriber's Name:	Subscriber I.D. Number:
Patient's Full Name:	Male ☐ or Female ☐ Birthdate: __/__/_____

Please indicate:
Medicare Plan Name:_____

I hereby authorize any pharmacy or provider to disclose the drug information of the prescription named hereon to *R/x^x*.
I also certify that I have received the prescription(s) that are shown below.

_____ _____
Signature of Subscriber **Date**

PART B ***Provider: Please complete all Part B areas***

Rx number	National Drug Code (NDC)	Qty	Day Supply	Date Dispensed Month / Day/Year	Cost of drug	Co-pay amount	

I certify that the above Part B information is true and correct. Totals:

_____ _____
Date

_____ _____
Provider / Pharmacy Name, Address and Phone Number Provider NABP Number

MEDICARE PART D REPORT MUST BE ATTACHED FOR PROCESSING.

To avoid claim returns and errors, please attach prescription receipts.
Please keep a copy for your records.