

## HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

**One Hartford Plaza  
Hartford, CT 06155  
(A stock insurance company)**



The Hartford Financial Services Group, Inc. (NYSE: HIG) operates through its subsidiaries under the brand name, The Hartford®. For additional information, see [www.thehartford.com](http://www.thehartford.com).

**Policy Numbers:** AGP#

**Policyholder: Los Rios Community College District**

Please print clearly in ink or type

Retiree's Name: \_\_\_\_\_

First	Middle	Last

Street: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Sex: ☐ Male ☐ Female      Date of Birth: \_\_\_\_\_      Medicare ID #: \_\_\_\_\_

Date of Retirement: \_\_\_\_\_

Spouse's Name (Only if enrolling): \_\_\_\_\_

First	Middle	Last

Street: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Sex: ☐ Male ☐ Female Date of Birth: Medicare ID #:

Date of Retirement:

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

**PLEASE ANSWER ALL QUESTIONS.** Please mark Yes or No below with an “X”

To the best of your knowledge:

1. A) In the last 6 months, did you turn age 65?

Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

B) Have you, or your spouse if enrolling, enrolled in Medicare Part B in the last 6 months?

Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If yes, what is the effective date? Retiree:            /    /            Spouse:            /    /

If no, when do you intend to enroll? Retiree                      Spouse

2. Are you covered for medical assistance through the state Medicaid program?

Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

(NOTE TO APPLICANT: If you are participating in a “Spend-Down Program” and have not met your “Share of Cost,” please answer NO to this question.)

Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If yes,

A) Will Medicaid pay your premiums for this Medicare supplement policy?

Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

B) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

3. If you had coverage under any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave “END” blank.

Retiree:        /    /        END        /    /        Spouse: START:        /    /        END        /    /

4. Have you had coverage under **any** other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)

Retiree: ☐ Yes ☐ No      Spouse: ☐ Yes ☐ No

A) If so, with what company and what kind of policy?

Retiree: Date of Retirement: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Number:\_\_\_\_\_

Spouse: Date of Retirement: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Number:

B) What are your dates of coverage under the other policy (If you are still covered under the other policy, leave "END" blank.)?

Retiree: \_\_\_\_\_ Spouse: \_\_\_\_\_  
START: \_\_\_\_/\_\_\_\_/\_\_\_\_ END: \_\_\_\_/\_\_\_\_/\_\_\_\_ START: \_\_\_\_/\_\_\_\_/\_\_\_\_ END: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. If you are still covered under any other coverage, do you, or your spouse if enrolling, intend to replace these medical, Medicare, or health policies with this policy or certificate?

Retiree: ☐ Yes ☐ No      Spouse: ☐ Yes ☐ No

PLEASE NOTE

- (1) You, your Spouse, do not need more than one Medicare supplement policy.
- (2) If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (4) If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement certificate can be suspended if requested during your entitlement to benefits under Medicaid for twenty-four months. You must request this suspension within ninety days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstituted if requested within ninety days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (5) If you are eligible for, and have enrolled in a Medicare supplement certificate by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement certificate can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement certificate under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

✓ Please check desired coverage:

	Effective Date	Plan F-Extra
Retiree		<input type="checkbox"/>
Spouse		<input type="checkbox"/>

**Benistar – Eligibility Dept.**  
**10 Tower Lane, Suite 100**  
**Avon, CT 06001**  
**1-800-236-4782**

## FRAUD NOTICE

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**PRE-EXISTING CONDITION LIMITATION NOTICE**

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.

The Company will waive the Pre-Existing Condition Limitation to the extent that it was met under any prior Medicare Supplement policy. If this plan replaces another Medicare Supplement Policy which has been in effect for at least six (6) months, the Company will not exclude benefits based on a Pre-Existing Condition.

**SIGNATURES**

Date: \_\_\_\_\_ Retiree Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Spouse Signature: \_\_\_\_\_  
(If enrolling)

**MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM**  
**Los Rios Community College District SPONSORED GROUP PLAN**

**To enroll in Express Scripts Medicare® (PDP)  
please provide the following information:**

Desired Effective Date: \_\_\_\_\_

LAST Name:		FIRST Name:		MIDDLE Initial:		Mr.   Mrs.   Ms.	
Birth Date: (____/____/____) (MM/DD/YYYY)		Gender: M   F	Cell Phone Number: (   )		Home Phone Number: (   )		
Permanent Residence Street Address (P.O. Box is not allowed):							
City:				State:		ZIP Code:	
<b>Mailing Address</b> (only if different from your Permanent Residence Address):							
Street Address:				City:		State:      ZIP Code:	
<b>Emergency Contact:</b> [Optional]							
<b>Phone Number:</b> [Optional] _____ <b>Relationship to You</b> [Optional] _____							
<b>E-mail Address:</b> [Optional]							
<b>Please Provide Your Medicare Insurance Information</b>							
<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"><li>• Please fill in these blanks so they match your red, white and blue Medicare card.</li></ul> <p>- OR -</p> <ul style="list-style-type: none"><li>• Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</li></ul> <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>				Name: _____			
				Medicare Number _____-_____-_____			
				<u>OR</u> Medicare Claim Number _____-_____-_____			
				Is Entitled To			
				Effective Date			
<b>HOSPITAL (Part A)</b>				_____			
<b>MEDICAL (Part B)</b>				_____			

**Please read and answer these important questions:**

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

Will you have other prescription drug coverage in addition to your former Employer's retiree plan? Yes No  
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage.

**Name of other coverage:**

**ID # for this coverage:**

**Group # for this coverage:**

**Important Information About Your Medicare Part D Prescription Drug Plan**

**Express Scripts Medicare®** (PDP), is offered by Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). (When this document says "we," "us" or "our," it means Medco Containment Life Insurance Company or Medco Containment Insurance Company of New York (for employer plans domiciled in New York). When it says "plan" or "our plan," it means Express Scripts Medicare.) This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

**Enrollment Requirements**

You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

**IMPORTANT: Read and Sign Below:**

- **Release of Information:** By joining this Medicare Advantage Prescription Drug Plan/Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Express Scripts will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S.border.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under State law to complete this enrollment, and
  - 2) Documentation of this authority is available upon request by Medicare.

<b>Signature:</b>	<b>Today's Date:</b>
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Address:
Phone Number:	Relationship to Enrollee:

## OPTIONAL INFORMATION

Answering these questions is your choice.

You can't be denied coverage because you don't fill them out.

**Are you Hispanic, Latino/a, or Spanish origin?** Select all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Cuban   |
| <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a        | <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |
| <input type="checkbox"/> Yes, Puerto Rican                                | <input type="checkbox"/> I choose not to answer                             |

**What is your race?** Select all that apply.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Japanese              | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Korean                | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Native Hawaiian       | <input type="checkbox"/> White                  |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Asian           | <input type="checkbox"/> I choose not to answer |

**Select if you want us to send you information in a language other than English.**

- ☐ Spanish

**Select one if you want us to send you information in an accessible format.**

- ☐ Braille    ☐ Large print    ☐ Audio CD    ☐ Data CD

Please contact **Benistar at 1-800-236-4782** if you need information in an accessible format other than what's listed above. Office hours between **MONDAY – FRIDAY, 8:30 AM – 5:30 PM EST**.

**Go paperless! Reduce your clutter and help the environment.**

- ☐ I prefer that you send materials to me via email, if available. I understand that I can switch my preference back to mail at any time.

E-mail address:

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**One Hartford Plaza  
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**OUTLINE OF COVERAGE FOR LOS RIOS COMMUNITY COLLEGE DISTRICT****PLAN F-EXTRA****MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1676	\$1676 (Part A deductible)	\$0
61st thru 90th day	All but \$419	\$419 a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$838	\$838 a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital:			
First 20 days	All approved Amounts	\$0	\$0
21st thru 100th day	All but \$209.50 /day	Up to \$209.50 / day	\$0
101st day and after	\$0	\$0	All costs



### PLAN F-EXTRA

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN F-EXTRA

### MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:  First \$257 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	          \$0          Generally 80%	          \$257 (Part B deductible)          Generally 20%	          \$0          \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints  Next \$257 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	          \$0          80%	          All costs          \$257 (Part B deductible)          20%	          \$0          \$0          \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES—TESTS FOR</b> <b>DIAGNOSTIC SERVICES</b>	100%	\$ 0	\$0

## PLAN F-EXTRA

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES  Medically necessary skilled care services and medical supplies  —Durable medical equipment  First \$257 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	          100%          \$0          80%	          \$0          \$257 (Part B deduct.)          20%	          \$0          \$0          \$0

### OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.  First \$250 each calendar year  Remainder of charges	          \$0          \$0	          \$0          80% to a lifetime maximum benefit of \$50,000	          \$250          20% and amounts over the \$50,000 lifetime maximum

### INNOVATIVE BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>ANNUAL PHYSICAL EXAM</b> Exam may include a review of medical history and a discussion of risk factor reductions and other services performed as part of an annual exam, which are not covered by Medicare or under another benefit in the policy.	\$0	100% of the remaining covered expenses incurred, after the Covered Person's payment, up to the Annual Physical Benefit maximum of \$500 per Calendar Year.	\$25 Policy Copayment per visit.

## PLAN F-EXTRA

### INNOVATIVE BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>CHIROPRACTIC SERVICES BENEFIT</b> Services performed by a licensed chiropractor to correct structural alignment.	\$0 for non-Medicare covered services (Medicare only covers spinal manipulations)	100% of the remaining covered expenses incurred, after the Covered Person's payment, up to the Chiropractic Benefit maximum of \$500 per Calendar Year.	\$25 Policy Copayment per visit.
<b>ACUPUNCTURE SERVICES BENEFIT</b> Services performed by a licensed acupuncturist to treat pain.	\$0 for non-Medicare covered services (Medicare only covers for chronic low back pain)	100% of the remaining covered expenses incurred, after the Covered Person's payment, up to the Acupuncture Benefit maximum of \$500 per Calendar Year.	\$25 Policy Copayment per visit.

# Benefit Overview

## Express Scripts Medicare® (PDP)

### YOUR 2026 PRESCRIPTION DRUG PLAN BENEFIT: Los Rios Community College District

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

<b>Deductible stage</b>	You do not pay a yearly deductible.				
<b>Initial Coverage stage</b>	You will pay the following until your total yearly drug costs (what you and the plan pay) reach \$2,100:				
	<b>Tier</b>	<b>Retail One-Month (31-day) Supply</b>	<b>Retail Two-Month (32-60-day) Supply</b>	<b>Retail Three-Month (90-day) Supply</b>	<b>Express Scripts Pharmacy by Evernorth® Home Delivery Three-Month (90-day) Supply</b>
	Tier 1: <b>Preferred Generic Drugs</b>	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
	Tier 2: <b>Generic Drugs</b>	\$5 copayment	\$10 copayment	\$15 copayment	\$10 copayment
	Tier 3: <b>Preferred Brand Drugs</b>	\$15 copayment	\$30 copayment	\$45 copayment	\$30 copayment
	Tier 4: <b>Non-Preferred Drugs</b>	\$30 copayment	\$60 copayment	\$90 copayment	\$60 copayment
	Tier 5: <b>Specialty Tier Drugs</b>	\$30 copayment	\$60 copayment	\$90 copayment	\$60 copayment
	You may receive more than a one-month supply of certain maintenance drugs (medications taken on a long-term basis) by mail through Express Scripts Pharmacy by Evernorth. There is				

	<p>no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.</p> <p>If you have any questions about this coverage, please contact the Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.</p>
<b>Catastrophic Coverage stage</b>	<p><b>If you reach the Catastrophic Coverage stage, you pay nothing for covered Part D drugs.</b></p> <p><b>You may have cost sharing for excluded drugs that may be covered under our enhanced benefit, if our plan covers additional drugs not normally covered by Medicare Part D.</b></p>

## IMPORTANT PLAN INFORMATION

### Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one-month supply of generic drugs at a time. Contact your plan if you have questions about cost sharing or billing when less than a one-month supply is dispensed.

### Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact the plan or the Retiree Customer Service Center for more details.

### Additional Information About This Coverage

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.
- To find a network pharmacy near you, visit our website at **[express-scripts.com/pharmacies](https://www.express-scripts.com/pharmacies)**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts Medicare will notify you before the change is made.
- A PDF of our printed drug list for 2026 will be available by logging into **[express-scripts.com/documents](https://www.express-scripts.com/documents)** beginning on October 15, 2025.
- Most adult Part D vaccines are covered at no cost to you.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- Your cost-sharing amount may differ from the information shown in this chart if you use a home delivery pharmacy other than Express Scripts Pharmacy by Evernorth. Other pharmacies are available in our network.
- The Medicare Prescription Payment Plan is an option to help you manage your out-of-pocket drug costs. This payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year (January – December).** **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- Each month, you may need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is \$0.
- When you use your Part D prescription drug benefits, Express Scripts Medicare sends you an *Explanation of Benefits* (Part D EOB), or summary, to help you understand and keep track of your benefits. You may also be able to receive a copy electronically by visiting our website, **express-scripts.com**, or by contacting the Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

This information is not a complete description of benefits. Call Customer Service at the numbers listed above for more information.

**Important Message About What You Pay for Insulin** – You won't pay more than \$35 for a one-month supply for each insulin product covered by our plan, no matter its cost-sharing tier. If your plan covers insulin at a lower cost-sharing amount, you will pay the lower amount. If your plan has a deductible, there is no deductible for covered insulins.

This document may be available in braille. Please call Customer Service at the phone numbers listed above for assistance.

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.  
Enrollment in Express Scripts Medicare depends on contract renewal.

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# YOUR RETIREE ADVOCATES

**EXPERTS IN MEDICARE  
NURTURING BY NATURE**

## ABOUT BENISTAR

Benistar Administrative Services, Inc. is our dedicated administrator for our Retiree Medical with Part D prescription drug coverage. Benistar specializes specifically in post-65 group retiree benefits administration. Benistar is here to assist you during this transition as well as throughout your coverage for anything you may need pertaining to your new health plans. You are now welcome to call Benistar at their service number which is highlighted below. You will immediately be put in touch with a live representative who can address any questions or concerns you may have and can assist directly or in coordination with your carriers.

## HOW WE SUPPORT YOU:

- ✓ **QUESTIONS ABOUT MEDICARE**
- ✓ **BILLING**
- ✓ **THE HARTFORD MEDICAL**
- ✓ **PROVIDER EDUCATION OUTREACH**
- ✓ **EXPRESS SCRIPTS PHARMACY**
- ✓ **PRIOR AUTHORIZATION ASSISTANCE**
- ✓ **REPLACEMENT DRUG FILLS**
- ✓ **CLAIMS ASSISTANCE**

## CONTACT BENISTAR:

☎ **1-800-236-4782**

✓ **HOURS:  
MONDAY TO FRIDAY  
8:30AM TO 5:30PM EST**

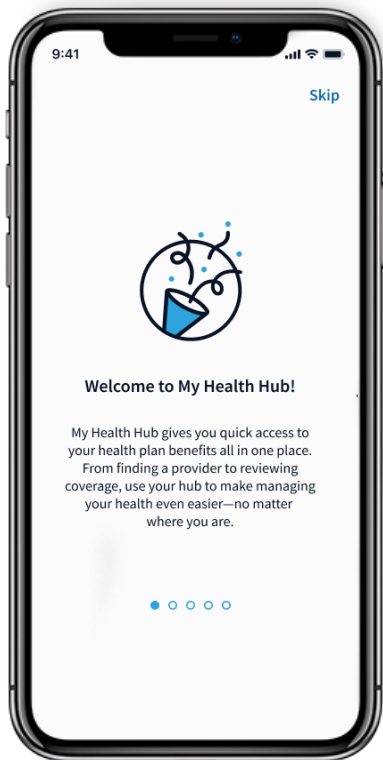


**ALL THE ABOVE WHILE NEVER  
BEING RUSHED OFF THE PHONE.  
YOU ARE BENISTAR'S PRIORITY**



## Your new Hartford Member Portal is here.

If you had an account on the previous Hartford Member Portal, you will need to re-register and use My Health Hub going forward. Your previous claims and health information will be loaded into your new account.



## Download the My Health Hub App

You can download the My Health Hub mobile app by visiting the Apple App store or Google Play for Android.



## Questions?

Call 877-480-2432 to speak with a dedicated customer service representative.

# Register on **Myhealthhub**



## Get started.

The instructions below are to register your My Health Hub account on the website or mobile app.

- 01** Go to **www.myhealthhub.app** or visit the app store and download the My Health Hub app.
- 02** Click **register now** and read the Terms and Conditions.
- 03** Complete the information on the form, and **agree to the Terms and Conditions** before clicking **continue**.
- 04** Verify your email address and click **continue**.
- 05** A verification code will be sent to the email address you provided. Enter the code and click **verify code**.
- 06** Here you can create your username and password. Follow the username and password requirements listed on the screen.
- 07** Now you can set your mobile app preferences such as allowing notifications and going paperless.
- 08** Click **go to homepage** and you will be able to start the onboarding steps.

The onboarding steps show you how to access your health plan information and reach out for assistance. If you do not want to take the onboarding steps, you can click "skip" to be redirected to your account homepage.



## *Living Boldly™ Together*

With the Silver&Fit® Healthy Aging and Exercise program, eligible members can enjoy:



### **Fitness Network Choices**

You can access a network of participating fitness centers or select YMCAs. You also have access to Premium locations, including fitness centers, studios, and unique fitness experiences, for a buy-up price.<sup>1</sup>



### **Home Fitness Kits**

You can pick one kit per benefit year from the available options.<sup>2</sup>



### **Well-Being Coaching**

You can get support in areas like fitness, healthy eating, stress, sleep, and losing weight while taking GLP-1 or anti-obesity medications. Trained coaches are available by phone, video, or chat.<sup>3</sup>



### **Fitness Tracking**

You can sync your wearable fitness tracker or mobile app to the Silver&Fit Connected!™ tool to track your activity.<sup>4</sup>



### **On-Demand Workout Videos**

You can view yoga, strength, Pilates, walking, cardio, and many other workout videos at [SilverandFit.com](https://SilverandFit.com).



### **Workout Plans**

By answering a few online questions, you can get a custom exercise plan that focuses on goals like getting stronger, staying fit during recovery, and chronic condition management.



### **Well-Being Club**

You can learn new skills and focus on your well-being by connecting with others, joining live virtual classes and events, and viewing exclusive articles and videos.



### **FitnessCoach™ Virtual Personal Training**

You can challenge yourself through virtual sessions with a certified personal trainer.<sup>5</sup>

# Go digital

For fast, simple and  
secure access to your  
prescription benefits

Express Scripts® Pharmacy Benefit Services manages the pharmacy portion of your health plan coverage to help make medication safer and more affordable. Just like your health plan covers your doctor visit, your pharmacy benefits or prescription plan covers the medication your doctor prescribes. Through your pharmacy benefits, you have access to a network of covered pharmacies and medications.

## Our pharmacy benefit capabilities



### Save on medications

Check the price of a medication before and during a doctor's visit.



### Find a pharmacy

Locate the most convenient network pharmacy for your needs.



### Coverage review

Before a doctor prescribes a medication, check to see if it needs a coverage review.



### Set reminders

Set reminders to take your medication and sign up for text alerts.

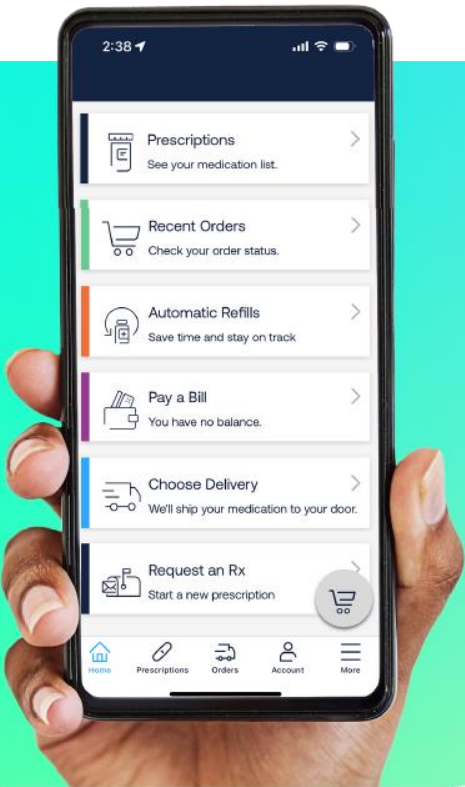
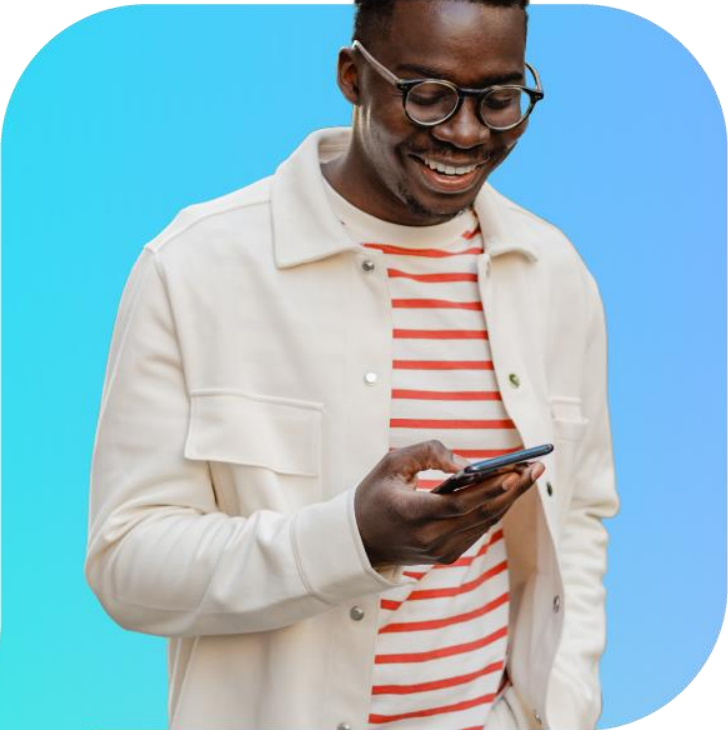
# Get started now

Visit **express-scripts.com** to learn more about our pharmacy benefit services, so you can stress less and save more.

## Download our new mobile app

Use the QR code or search Express Scripts® in your **app store**.

Download the app for free, then tap Register Now to get started.



## EXPRESS SCRIPTS PHARMACY BENEFIT SERVICES

# Get the most from your prescription benefit



Express Scripts® Pharmacy Benefit Services manages the pharmacy portion of your health plan coverage to help make medication safer and more affordable. Just like your health plan covers your doctor visit, your pharmacy benefits or prescription plan cover the medication your doctor prescribes. Through your pharmacy benefits, you have access to a network of covered pharmacies and medications.

Express Scripts is committed to delivering exceptional pharmacy care so you can stress less and save more. Visit [express-scripts.com](https://express-scripts.com) to learn more about how we provide pharmacy benefits you can depend on.

### 1 Go digital

Get anywhere, anytime access to your pharmacy benefits with an online account. It's simple to start—it takes just 5 clicks and 2 minutes and you'll have access to view your plan details, coverage and benefits anytime, anywhere. Sign up at [express-scripts.com](https://express-scripts.com) or scan the QR code below.

#### An online account provides you with:

##### Instant digital ID card

Keep it on you 24/7. Download it to your phone, print a copy or do both. You can even save your ID card to your mobile wallet.

##### Money-saving recommendations

Log in today to get your personalized, proactive money-saving recommendations.

##### Rx and claims history

Manage your prescriptions, review your prescription history and medication spend, all in one place.

##### Coverage review updates

Before a doctor prescribes a medication, find out if it needs coverage review like prior authorization and check the status of an in-process review.

##### Helpful tools

Receive alerts on the go by signing up for text messages. Log in and go to Communication Preferences in your account.

### 2 Stress less

Ask your doctor if a 3-month supply is an option vs. a 1-month supply of your medication. Then request that your doctor send your 3-month prescription to Express Scripts® Pharmacy for home delivery to save you even more.

#### You can also:

**Transfer an existing prescription to home delivery by clicking Add to Cart**

#### For new prescriptions, you have three options:

- + Ask your doctor to send it to Express Scripts Pharmacy
- + Click the Request an Rx link on the online dashboard and we'll contact your doctor for you
- + Or print a home delivery form by selecting Forms under Benefits, then follow the mailing instructions

Sign up at  
[express-scripts.com](https://express-scripts.com)  
or scan this QR code.





### 3 Save more

Seeing your doctor? Ask if they use **Real-Time Prescription Benefit** to check for the most affordable pricing for you and to help avoid a coverage review like prior authorization.

If not, **use your online account during your visit to check pricing on any prescription**—a less costly option may be available that's just as effective. Request that medication instead.

#### These alternate options:

- + Help reduce costs and ensure you receive a safe and proven-effective medication
- + Usually are generic forms of brand-name drugs
- + Don't rely on coupons, which could cost you more over time

### Ask about switching to generic medications to save money on your prescriptions.

The easiest—and safest—way to save money on prescriptions is to ask for a generic, which typically costs less because the manufacturer did not have to conduct the initial research or studies that the branded drug did.

#### Generics fall into two categories:

- + Direct chemical equivalent—a drug that has the same active ingredient as its brand-name counterpart
- + Therapeutic alternative—a drug that may not be chemically equivalent to the brand, but has the same therapeutic or treatment effect

Direct chemical equivalents are practically identical to the branded drug, while therapeutic alternatives are part of the same family.

FDA-approved generics must adhere to strict guidelines and are the same as a brand-name medication in dosage, safety, effectiveness, strength, stability and quality.



#### Simple

- + Get the most from your prescription benefit
- + Our dashboard makes it easy for members, with everything in one place

#### Generics

- + Greater simplicity and convenience
- + Ask your doctor, "Is there a generic for that?"

#### RTPB

- + Ask your doctor if they use Real-Time Prescription Benefit
- + Avoid a coverage review like prior authorization

#### Go digital

- + Empowering members with 24/7 support
- + Manage your medications on the go and on your schedule with the Express Scripts® mobile app



**For additional information on how to take control of your prescription plan or any other questions about your account or coverage, visit [express-scripts.com](https://www.express-scripts.com), download the Express Scripts mobile app or call the Member Services number on your digital ID card.**