Evidence of Coverage 2021

Prescription Drug Plan

HealthSelect℠ Medicare Rx (PDP) provided through the Employees Retirement System of Texas (ERS)
Group Name: HealthSelect Medicare Rx
Group Number: 24731

Toll-free **(866) 868-0609**, (TTY: **711**)
7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT, Saturday

www.HSMedicareRx.com

United Healthcare

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January 1, 2021 – December 31, 2021

Evidence of Coverage:

HealthSelect Medicare Rx provided through the Employees Retirement System of Texas (ERS)

This booklet gives you the details about your Medicare prescription drug coverage January 1, 2021 – December 31, 2021. 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.**

This plan, HealthSelect Medicare Rx, is administered by UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means HealthSelect Medicare Rx.)

This document is available for free in other languages. Please contact our Customer Service number at (866) 868-0609 for additional information. (TTY users should call 711). Hours are 7 a.m. – 7 p.m. CT, Monday – Friday, 7 a.m. – 3 p.m. CT, Saturday.

This document may be available in an alternate format such as braille, large print or audio. Please contact Customer Service number at **(866) 868-0609** (TTY: **711**), 7 a.m. – 7 p.m. CT, Monday – Friday, 7 a.m. – 3 p.m. CT, Saturday, for additional information.

The benefits, deductible, and/or copayments/coinsurance may change on January 1, 2022.

The formulary, pharmacy network and provider network may change at any time. You will receive notice when necessary.

OMB Approval 0938-1051 (Expires: December 31, 2021)

2021 Evidence of Coverage

Table of Contents

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Getting started as a member

Chapter 1

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are a member of the HealthSelect Medicare Rx, which is a Medicare Prescription Drug plan

You are covered by Original Medicare for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, HealthSelect Medicare Rx.

There are different types of Medicare plans. HealthSelect Medicare Rx is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the Evidence of Coverage booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare prescription drug coverage through your plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The words “coverage” and “covered drugs” refer to the prescription drug coverage available to you as a member of the plan.

It’s important for you to learn what the plan’s rules are and what coverage is available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** booklet.

If you are confused or concerned or just have a question, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the Evidence of Coverage

It’s part of our contract with you

This **Evidence of Coverage** is part of our contract with you about how HealthSelect Medicare Rx covers your care. Other parts of this contract include the **List of Covered Drugs (Formulary)**, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are a member of this plan between January 1, 2021 and December 31, 2021.

Each plan year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of HealthSelect Medicare Rx after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve this plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve HealthSelect Medicare Rx each year. You can continue to get Medicare coverage as a member of your plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in this plan as long as:

- You meet the eligibility requirements of ERS
- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B) (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- — **and** — You are a United States citizen or are lawfully present in the United States
- — **and** — You live in our geographic service area (Section 2.3 below describes our service area)

Section 2.2 What are Medicare Part A and Medicare Part B?

As discussed in Section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through this plan. This plan has contracted with Medicare to provide you with most of these Medicare benefits. We describe the drug coverage you receive under your Medicare Part D coverage in Chapter 3.

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).

Section 2.3 Here is the plan service area for HealthSelect Medicare Rx

HealthSelect Medicare Rx is available only to individuals who live in this plan's service area. To remain a member of this plan, you must continue to reside in the plan service area. The service area is described below.

The service area for this plan includes the 50 United States, the District of Columbia and all U.S. Territories.

Please Note: If you use a Post Office Box, you will need to provide proof that you live in the plan's service area.

If you plan to move out of the service area, please contact your employer's benefits administrator and update your address.

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 Chapter 2, Section 5.

Section 2.4 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 HealthSelect Medicare Rx if you are not eligible to remain a member on this basis.

HealthSelect Medicare Rx must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your UnitedHealthcare member ID card – Use it to get all covered prescription drugs

While you are a member of this plan, you must use your UnitedHealthcare member ID card for your plan for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample UnitedHealthcare member ID card to show you what yours will look like:

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your UnitedHealthcare member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You may need to use your new red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for plan members.

Why do you need to know about network pharmacies?

You can use the Pharmacy Directory to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.HSMedicareRx.com. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. Please review the 2021 Pharmacy Directory to see which pharmacies are in our network.

The Pharmacy Directory is located on our website at www.HSMedicareRx.com. You may request a copy of the Pharmacy Directory be mailed to you by calling Customer Service (phone numbers are printed on the back cover of this booklet).

Section 3.3 The plan's List of Covered Drugs (Formulary)

The plan has a **List of Covered Drugs (Formulary)**. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by your plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

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

To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.HSMedicareRx.com) or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 3.4 The Part D Explanation of Benefits (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

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

The **Part D Explanation of Benefits** tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. 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. Chapter 4 (**What you pay for your Part D prescription drugs**) gives more information about the **Part D Explanation of Benefits** and how it can help you keep track of your drug coverage.

A Part D Explanation of Benefits summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for HealthSelect Medicare Rx

Section 4.1 Your monthly premium for HealthSelect Medicare Rx

Please contact ERS for more information about the premium for this plan.

You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium (if applicable) could be less

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are **already enrolled** and getting help from one of these programs, the **information about premiums in this Evidence of Coverage may not apply to you**. We sent you 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 don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

If you pay a premium, in some situations, your plan premium (if applicable) could be more

In some situations, if you pay a plan premium, your premium could be higher. Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium. Chapter 1, Section 6 explains the IRMAA in further detail.

ERS has elected to pay for your Part D late enrollment penalty on your plan. However, if you join another plan your Part D late enrollment penalty may not be covered and you may be responsible for paying your late enrollment penalty.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage.

"Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

ERS has elected to pay for your late enrollment penalty on your plan. However, if you join another plan, your late enrollment penalty may not be covered and you may be responsible for paying your late enrollment penalty.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2021, this average premium amount is $33.06.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $33.06, which equals $4.63. This rounds to $4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are **under** 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." **Please note:**
  - Creditable coverage could include drug coverage from a former employer, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are **not** creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your **Medicare & You 2021** Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty. Call Customer Service to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your late enrollment penalty while you're waiting for a review of the decision. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

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 have to pay an extra amount, Social Security, not your Medicare plan, 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, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, 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.**

Section 6.2 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.

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you **will** be disenrolled from the plan and lose prescription drug coverage.

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B.

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 plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.

- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of **Medicare & You 2021** 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 2021** from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 7.1 Can we change your monthly plan premium (if applicable) during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you at least 15 days prior to January 1. ERS establishes the base premium rate.

However, in some cases, the part of the premium that you have to pay can change during the year (if you are paying any portion of your premium). This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8 Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from ERS' enrollment file, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's 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.

When moving, you should always contact your employer's benefits administrator and update your name, address, and telephone number.

If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

Let UnitedHealthcare Customer Service know about these changes:

- 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 us know by calling Customer Service (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. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other 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 Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan 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 employer group health plan coverage:

- If you have retiree coverage, Medicare pays first.

- If your group health plan 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, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- 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 Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your UnitedHealthcare member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time. Visit www.medicare.gov to review additional information regarding Coordination of Benefits.

Chapter 2

Important phone numbers and resources

Chapter 2

Important phone numbers and resources

SECTION 1 HealthSelect Medicare Rx Contacts (how to contact us, including how to reach UnitedHealthcare Customer Service)

How to contact UnitedHealthcare's Customer Service

For assistance with claims or UnitedHealthcare member ID card questions, please call or write to UnitedHealthcare Customer Service. We will be happy to help you.

Method	UnitedHealthcare Customer Service – Contact Information
CALL	**(866) 868-0609** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
FAX	**(888) 950-1169**
WRITE	UnitedHealthcare Customer Service Department P.O. Box 30769 Salt Lake City, UT 84130-0769
WEBSITE	**www.HSMedicareRx.com**

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	**(866) 868-0609** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
WRITE	OptumRx Prior Authorization Department P.O. Box 25183, Santa Ana, CA 92799
WEBSITE	**www.HSMedicareRx.com**

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 7 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	**(866) 868-0609** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
FAX	**(877) 960-8235**
WRITE	UnitedHealthcare Part D Appeals and Grievances Department P.O. Box 6103, MS CA124-0197 Cypress, CA 90630-0023

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about this plan or one of the plan's network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 7 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).

Method	Complaints about Part D Prescription Drugs – Contact Information
CALL	**(866) 868-0609** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
FAX	**(877) 960-8235**
WRITE	UnitedHealthcare Part D Appeals and Grievances Department P.O. Box 6103, MS CA124-0197 Cypress, CA 90630-0023
MEDICARE WEBSITE	You can submit a complaint about HealthSelect Medicare Rx directly to Medicare. To submit an online complaint to Medicare go to **www.medicare.gov/MedicareComplaintForm/home.aspx**.

Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (**Asking us to pay our share of the costs for covered drugs**).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**) for more information.

Method	Payment Requests – Contact Information
CALL	**(866) 868-0609** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT Saturday
WRITE	Part D prescription drug payment requests: OptumRx P.O. Box 650287 Dallas, TX 75265-0287

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

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 us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

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. Because your coverage is provided by ERS, you will not find HealthSelect Medicare Rx listed on www.medicare.gov. 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 your plan: • **Tell Medicare about your complaint:** You can submit a complaint about your plan 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 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- Alaska – Alaska Medicare Information Office
- Alabama – Alabama State Health Insurance Assistance Program (SHIP)
- Arkansas – Arkansas Senior Health Insurance Information Program (SHIIP)
- American Samoa – American Samoa Senior Health Insurance Program
- Arizona – Arizona State Health Insurance Assistance Program
- California – California Health Insurance Counseling & Advocacy Program (HICAP)
- Colorado – Colorado Senior Health Insurance Assistance Program (SHIP)
- Connecticut – Connecticut CHOICES Senior Health Insurance Program
- District of Columbia – Department of Aging and Community Living
- Delaware – Delaware Medicare Assistance Bureau (DMAB)
- Florida – Florida Serving Health Insurance Needs of Elders (SHINE)
- Georgia – GeorgiaCares Senior Health Insurance Plan
- Guam – Guam Medicare Assistance Program (GUAM MAP)
- Hawaii – Hawaii SHIP
- Iowa – Iowa Senior Health Insurance Information Program (SHIIP)
- Idaho – Idaho Senior Health Insurance Benefits Advisors (SHIBA)
- Illinois – Illinois Senior Health Insurance Program (SHIP)
- Indiana – Indiana State Health Insurance Assistance Program (SHIP)
- Kansas – Kansas Senior Health Insurance Counseling for Kansas (SHICK)
- Kentucky – Kentucky State Health Insurance Assistance Program (SHIP)
- Louisiana – Louisiana Senior Health Insurance Information Program (SHIIP)
- Massachusetts – Massachusetts Serving the Health Insurance Needs of Everyone (SHINE)
- Maryland – Maryland Department of Aging – Senior Health Insurance Assistance Program (SHIP)
- Maine – Maine State Health Insurance Assistance Program (SHIP)
- Michigan – Michigan MMAP, Inc. Senior Health Insurance Program
- Minnesota – Minnesota State Health Insurance Assistance Program/Senior LinkAge Line
- Missouri – Missouri CLAIM Senior Health Insurance Program

- North Mariana Islands – North Mariana Islands Senior Health Insurance Program
- Mississippi – Mississippi Department of Human Services, Division of Aging & Adult Services
- Montana – Montana State Health Insurance Assistance Program (SHIP)
- North Carolina – North Carolina Seniors Health Insurance Information Program (SHIIP)
- North Dakota – North Dakota Senior Health Insurance Counseling (SHIC)
- Nebraska – Nebraska Senior Health Insurance Information Program (SHIIP)
- New Hampshire – New Hampshire SHIP – ServiceLink Aging and Disability Resource Center
- New Jersey – New Jersey State Health Insurance Assistance Program (SHIP)
- New Mexico – New Mexico Benefits Counseling Program SHIP
- Nevada – Nevada State Health Insurance Assistance Program (SHIP)
- New York – New York Health Insurance Information Counseling and Assistance Program (HIICAP)
- Ohio – Ohio Senior Health Insurance Information Program (OSHIIP)
- Oklahoma – Oklahoma Medicare Assistance Program (MAP)
- Oregon – Oregon Senior Health Insurance Benefits Assistance (SHIBA)
- Pennsylvania – Pennsylvania APPRISE Senior Health Insurance Program
- Puerto Rico – Puerto Rico State Health Insurance Assistance Program (SHIP)
- Rhode Island – Rhode Island State Health Insurance Assistance Program (SHIP)
- South Carolina – South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders
- South Dakota – South Dakota Senior Health Information & Insurance Education (SHIINE)
- Tennessee – Tennessee Commission on Aging & Disability – TN SHIP
- Texas – Texas Department of Aging and Disability Services (HICAP)
- Utah – Utah Senior Health Insurance Information Program (SHIP)
- Virginia – Virginia Insurance Counseling and Assistance Program (VICAP)
- Virgin Islands – Virgin Islands State Health Insurance Assistance Program (VISHIP)
- Vermont – Vermont State Health Insurance Assistance Program (SHIP)
- Washington – Washington Statewide Health Insurance Benefits Advisors (SHIBA)
- Wisconsin – Wisconsin SHIP (SHIP) State Health Insurance Plan
- West Virginia – West Virginia State Health Insurance Assistance Program (WV SHIP)
- Wyoming – Wyoming State Health Insurance Information Program (WSHIIP)

Your 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. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Alaska | Alaska Medicare Information Office 240 Main ST, STE 601 Juneau, AK 99811-0680 http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx	1-866-465-3165 TTY 1-907-465-5430
Alabama | Alabama State Health Insurance Assistance Program (SHIP) 201 Monroe ST, STE 350 Montgomery, AL 36104 www.AlabamaAgeline.gov	1-800-243-5463 TTY 711
Arkansas | Arkansas Senior Health Insurance Information Program (SHIIP) 1200 W Third ST Little Rock, AR 72202 https://insurance.arkansas.gov/pages/consumer-services/senior-health/	1-800-224-6330 TTY 711
American Samoa | American Samoa Senior Health Insurance Program ASTCA Executive Building #304, P.O. Box 998383 Pago Pago, AS 96799 www.medicaid.as.gov	1-684-699-4777 TTY 711
Arizona | Arizona State Health Insurance Assistance Program 1366 E Thomas RD, STE 108 ATTN: SHIP Phoenix, AZ 85104 https://des.az.gov/services/aging-and-adult/state-health-insurance-assistance-program-ship	1-800-432-4040 TTY 711
California | California Health Insurance Counseling & Advocacy Program (HICAP) 1300 National DR, STE 200 Sacramento, CA 95834-1992 http://www.aging.ca.gov/hicap/	1-800-434-0222 TTY 1-800-735-2929
Colorado | Colorado Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, STE 850 Denver, CO 80202 https://www.colorado.gov/pacific/dora/senior-healthcare-medicare	1-888-696-7213 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Connecticut | Connecticut CHOICES Senior Health Insurance Program 55 Farmington AVE, FL 12 Hartford, CT 06105-3730 http://www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313032	1-800-994-9422 TTY 711
District of Columbia | Department of Aging and Community Living 500 K Street, NE Washington, DC 20002 https://dcoa.dc.gov/	1-202-724-5626 TTY 711
Delaware | Delaware Medicare Assistance Bureau (DMAB) 1351 West N ST, STE 101 Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	1-800-336-9500 TTY 711
Florida | Florida Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, STE 270 Tallahassee, FL 32399-7000 www.floridashine.org	1-800-963-5337 TTY 1-800-955-8770
Georgia | GeorgiaCares Senior Health Insurance Plan 2 Peachtree ST NW, FL 33 Atlanta, GA 30303 www.mygeorgiacares.org	1-866-552-4464 TTY 711
Guam | Guam Medicare Assistance Program (GUAM MAP) 130 University DR, STE 8, University Castle Mall Mangilao, GU 96913 http://dphss.guam.gov/	1-671-735-7421 TTY 1-671-735-7415
Hawaii | Hawaii SHIP No. 1 Capitol District, 250 S Hotel ST, STE 406 Honolulu, HI 96813-2831 www.hawaiiship.org	1-888-875-9229 TTY 1-866-810-4379
Iowa | Iowa Senior Health Insurance Information Program (SHIIP) 601 Locust ST, FL 4 Des Moines, IA 50309-3738 http://www.shiip.state.ia.us/	1-800-351-4664 TTY 1-800-735-2942
Idaho | Idaho Senior Health Insurance Benefits Advisors (SHIBA) 700 W State ST, P.O. Box 83720 Boise, ID 83720-0043 http://www.doi.idaho.gov/SHIBA/	1-800-247-4422 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Illinois | Illinois Senior Health Insurance Program (SHIP) One Natural Resources Way, STE 100 Springfield, IL 62702-1271 http://www.illinois.gov/aging/ship/Pages/default.aspx	1-800-252-8966 TTY 1-888-206-1327
Indiana | Indiana State Health Insurance Assistance Program (SHIP) 311 W Washington ST, STE 300 Indianapolis, IN 46204-2787 http://www.in.gov/idoi/2495.htm	1-800-452-4800 TTY 1-866-846-0139
Kansas | Kansas Senior Health Insurance Counseling for Kansas (SHICK) New England BLDG, 503 S Kansas AVE Topeka, KS 66603-3404 http://www.kdads.ks.gov/SHICK/shick_index.html	1-800-860-5260 TTY 1-785-291-3167
Kentucky | Kentucky State Health Insurance Assistance Program (SHIP) 275 E Main ST, 3E-E Frankfort, KY 40621 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	1-877-293-7447 TTY 1-800-627-4702
Louisiana | Louisiana Senior Health Insurance Information Program (SHIIP) P.O. Box 94214 Baton Rouge, LA 70804 http://www.ldi.la.gov/SHIIP/	1-800-259-5300 TTY 711
Massachusetts | Massachusetts Serving the Health Insurance Needs of Everyone (SHINE) 1 Ashburton PL, RM 517 Boston, MA 02108 http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html	1-800-243-4636 TTY 1-800-439-2370
Maryland | Maryland Department of Aging – Senior Health Insurance Assistance Program (SHIP) 301 W Preston ST, STE 1007 Baltimore, MD 21201 https://aging.maryland.gov/Pages/state-health-insurance-program.aspx	1-800-243-3425 TTY 711
Maine | Maine State Health Insurance Assistance Program (SHIP) 11 State House Station, 41 Anthony AVE Augusta, ME 04333 https://www.maine.gov/dhhs/oads/community-support/ship.html	1-800-262-2232 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Michigan | Michigan MMAP, Inc. Senior Health Insurance Program 5303 S Cedar ST Lansing, MI 48911 www.mmapinc.org	1-800-803-7174 TTY 711
Minnesota | Minnesota State Health Insurance Assistance Program/Senior LinkAge Line P.O. Box 64976 St. Paul, MN 55164-0976 http://www.mnaging.org/en/Advisor/SLL.aspx	1-800-333-2433 TTY 1-800-627-3529
Missouri | Missouri CLAIM Senior Health Insurance Program 4215 Philips Farm RD STE 101-A Columbia, MO 65101 www.missouriclaim.org	1-800-390-3330 TTY 711
North Mariana Islands | North Mariana Islands Senior Health Insurance Program P.O. Box 5795 CHRB Saipan, MP 96950 http://commerce.gov.mp/	1-670-664-3000 TTY 711
Mississippi | Mississippi Department of Human Services, Division of Aging & Adult Services 200 S Lamar ST Jackson, MS 39201 http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/	1-601-359-4500 TTY 711
Montana | Montana State Health Insurance Assistance Program (SHIP) 1100 N Last Chance Gulch, FL 4 Helena, MT 59601 http://dphhs.mt.gov/sltc/aging/ship.aspx	1-800-551-3191 TTY 711
North Carolina | North Carolina Seniors Health Insurance Information Program (SHIIP) 325 N. Salisbury ST Raleigh, NC 27603 http://www.ncdoi.com/SHIIP/Default.aspx	1-855-408-1212 TTY 711
North Dakota | North Dakota Senior Health Insurance Counseling (SHIC) 600 E BLVD AVE Bismarck, ND 58505-0320 http://www.nd.gov/ndins/shic/	1-888-575-6611 TTY 1-800-366-6888
Nebraska | Nebraska Senior Health Insurance Information Program (SHIIP) 1033 O ST, STE 307 Lincoln, NE 68508 http://www.doi.nebraska.gov/shiip/	1-800-234-7119 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
New Hampshire | New Hampshire SHIP – ServiceLink Aging and Disability Resource Center 2 Industrial Park DR, P.O. Box 1016 Concord, NH 03302-1016 http://www.nh.gov/servicelink/	1-866-634-9412 TTY 1-800-735-2964
New Jersey | New Jersey State Health Insurance Assistance Program (SHIP) P.O. Box 715 Trenton, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/services/ship/index.html	1-800-792-8820 TTY 711
New Mexico | New Mexico Benefits Counseling Program SHIP P.O. Box 27118 Santa Fe, NM 87502-7118 www.nmaging.state.nm.us	1-800-432-2080 TTY 1-505-476-4937
Nevada | Nevada State Health Insurance Assistance Program (SHIP) 3416 Goni RD, STE D-132 Carson City, NV 89706 http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/	1-800-307-4444 TTY 711
New York | New York Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza 5 FL Albany, NY 12223 https://aging.ny.gov/health-insurance-information-counseling-and-assistance	1-800-701-0501 TTY 711
Ohio | Ohio Senior Health Insurance Information Program (OSHIIP) 50 W Town ST, STE 300, FL 3 Columbus, OH 43215 https://insurance.ohio.gov/wps/portal/gov/odi/consumers	1-800-686-1578 TTY 1-614-644-3745
Oklahoma | Oklahoma Medicare Assistance Program (MAP) 400 NE 50th ST Oklahoma City, OK 73105 https://www.oid.ok.gov/consumers/information-for-seniors/	1-800-763-2828 TTY 711
Oregon | Oregon Senior Health Insurance Benefits Assistance (SHIBA) P.O. Box 14480 Salem, OR 97309-0405 http://healthcare.oregon.gov/shiba/Pages/index.aspx	1-800-722-4134 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Pennsylvania | Pennsylvania APPRISE Senior Health Insurance Program 555 Walnut ST, FL 5 Harrisburg, PA 17101-1919 https://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx	1-800-783-7067 TTY 711
Puerto Rico | Puerto Rico State Health Insurance Assistance Program (SHIP) Ponce de León AVE, PDA 16, EDIF 1064, 3er nivel San Juan, PR 00919-1179 http://www2.pr.gov/Directorios/Pages/InfoAgencia.aspx?PRIFA=152	1-787-721-6121 TTY 711
Rhode Island | Rhode Island State Health Insurance Assistance Program (SHIP) 57 Howard AVE, BLDG 57, Cranston, RI 02920 http://www.oha.ri.gov/SHIP/	1-401-462-3000 TTY 1-401-462-0740
South Carolina | South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais ST, STE 350 Columbia, SC 29201 https://www.getcaresc.com/guide/insurance-counseling-medicaremedicaid	1-800-868-9095 TTY 711
South Dakota | South Dakota Senior Health Information & Insurance Education (SHIINE) 2520 E Franklin St Pierre, SD 57501 www.shiine.net	1-877-331-4834 TTY 711
Tennessee | Tennessee Commission on Aging & Disability – TN SHIP Andrew Jackson BLDG, 502 Deaderick ST, FL 9 Nashville, TN 37243-0860 https://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program–ship-.html	1-877-801-0044 TTY 711
Texas | Texas Department of Aging and Disability Services (HICAP) P.O. Box 149104 Austin, TX 78714-9104 http://www.tdi.texas.gov/consumer/hicap/	1-800-252-9240 TTY 1-800-735-2989

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Utah | Utah Senior Health Insurance Information Program (SHIP) 195 N 1950 W Salt Lake City, UT 84116 https://daas.utah.gov/	1-800-541-7735 TTY 711
Virginia | Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest AVE, STE 100 Henrico, VA 23229 https://www.vda.virginia.gov/vicap.htm	1-800-552-3402 TTY 711
Virgin Islands | Virgin Islands State Health Insurance Assistance Program (VISHIP) 1131 King ST, STE 101 St. Croix, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	1-340-773-6449 TTY 711
Vermont | Vermont State Health Insurance Assistance Program (SHIP) 280 State DR, HC 2 S Waterbury, VT 05671-2070 http://asd.vermont.gov/services/ship	1-802-241-0294 TTY 711
Washington | Washington Statewide Health Insurance Benefits Advisors (SHIBA) P.O. Box 40255 Olympia, WA 98504-0255 https://www.insurance.wa.gov/medicare	1-800-562-6900 TTY 1-360-586-0241
Wisconsin | Wisconsin SHIP (SHIP) State Health Insurance Plan 1402 Pankratz ST, STE 111 Madison, WI 53704-4001 http://longtermcare.wi.gov/	1-800-242-1060 TTY 711
West Virginia | West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha BLVD E Charleston, WV 25305 www.wvship.org	1-877-987-4463 TTY 711
Wyoming | Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams AVE Riverton, WY 82501 www.wyomingseniors.com	1-800-856-4398 TTY 711

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Here is a list of the Quality Improvement Organizations in each state we serve:

- Alaska – KEPRO
- Alabama – KEPRO
- Arkansas – KEPRO
- American Samoa – Livanta BFCC-QIO Program
- Arizona – Livanta BFCC-QIO Program
- California – Livanta BFCC-QIO Program
- Colorado – KEPRO
- Connecticut – KEPRO
- District of Columbia – Livanta BFCC-QIO Program
- Delaware – Livanta BFCC-QIO Program
- Florida – KEPRO
- Georgia – KEPRO
- Guam – Livanta BFCC-QIO Program
- Hawaii – Livanta BFCC-QIO Program
- Iowa – Livanta BFCC-QIO Program
- Idaho – KEPRO
- Illinois – Livanta BFCC-QIO Program
- Indiana – Livanta BFCC-QIO Program
- Kansas – Livanta BFCC-QIO Program
- Kentucky – KEPRO
- Louisiana – KEPRO
- Massachusetts – KEPRO
- Maryland – Livanta BFCC-QIO Program
- Maine – KEPRO
- Michigan – Livanta BFCC-QIO Program
- Minnesota – Livanta BFCC-QIO Program
- Missouri – Livanta BFCC-QIO Program
- North Mariana Islands – Livanta BFCC-QIO Program
- Mississippi – KEPRO

- Montana – KEPRO
- North Carolina – KEPRO
- North Dakota – KEPRO
- Nebraska – Livanta BFCC-QIO Program
- New Hampshire – KEPRO
- New Jersey – Livanta BFCC-QIO Program
- New Mexico – KEPRO
- Nevada – Livanta BFCC-QIO Program
- New York – Livanta BFCC-QIO Program
- Ohio – Livanta BFCC-QIO Program
- Oklahoma – KEPRO
- Oregon – KEPRO
- Pennsylvania – Livanta BFCC-QIO Program
- Puerto Rico – Livanta BFCC-QIO Program
- Rhode Island – KEPRO
- South Carolina – KEPRO
- South Dakota – KEPRO
- Tennessee – KEPRO
- Texas – KEPRO
- Utah – KEPRO
- Virginia – Livanta BFCC-QIO Program
- Virgin Islands – Livanta BFCC-QIO Program
- Vermont – KEPRO
- Washington – KEPRO
- Wisconsin – Livanta BFCC-QIO Program
- West Virginia – Livanta BFCC-QIO Program
- Wyoming – KEPRO

Your state's Quality Improvement Organization has a group of doctors and other health care 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. The state's Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact your state's Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Quality Improvement Organization (QIO) – Contact Information	
Alaska | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-305-6759 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Alabama | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-317-0751 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Arkansas | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-315-0636 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
American Samoa | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-877-588-1123 TTY 1-855-887-6668 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Arizona | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-877-588-1123 TTY 1-855-887-6668 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
California | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-877-588-1123 TTY 1-855-887-6668 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Colorado | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-317-0891 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Connecticut | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-319-8452 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
District of Columbia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-396-4646 TTY 1-888-985-2660 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Delaware | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-396-4646 TTY 1-888-985-2660 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Florida | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-317-0751 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Georgia | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-317-0751 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Guam | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-877-588-1123 TTY 1-855-887-6668 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Hawaii | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-877-588-1123 TTY 1-855-887-6668 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Iowa | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-755-5580 TTY 1-888-985-9295 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Idaho | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-305-6759 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Illinois | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-524-9900 TTY 1-888-985-8775 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Indiana | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-524-9900 TTY 1-888-985-8775 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Kansas | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-755-5580 TTY 1-888-985-9295 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Kentucky | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-317-0751 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Louisiana | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-315-0636 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Massachusetts | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-319-8452 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Maryland | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-396-4646 TTY 1-888-985-2660 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Maine | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-319-8452 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Michigan | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-524-9900 TTY 1-888-985-8775 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Minnesota | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-524-9900 TTY 1-888-985-8775 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Missouri | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-755-5580 TTY 1-888-985-9295 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
North Mariana Islands | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-877-588-1123 TTY 1-855-887-6668 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Mississippi | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-317-0751 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Montana | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-317-0891 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
North Carolina | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-317-0751 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
North Dakota | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-317-0891 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Nebraska | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-755-5580 TTY 1-888-985-9295 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
New Hampshire | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-319-8452 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
New Jersey | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-866-815-5440 TTY 1-866-868-2289 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
New Mexico | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-315-0636 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Nevada | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-877-588-1123 TTY 1-855-887-6668 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
New York | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-866-815-5440 TTY 1-866-868-2289 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Ohio | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-524-9900 TTY 1-888-985-8775 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Oklahoma | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-315-0636 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Oregon | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-305-6759 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Pennsylvania | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-396-4646 TTY 1-888-985-2660 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Puerto Rico | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-866-815-5440 TTY 1-866-868-2289 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Rhode Island | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-319-8452 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
South Carolina | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-317-0751 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
South Dakota | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-317-0891 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Tennessee | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-317-0751 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Texas | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com/providers/transition	1-888-315-0636 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Utah | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-317-0891 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Virginia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-396-4646 TTY 1-888-985-2660 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Virgin Islands | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-866-815-5440 TTY 1-866-868-2289 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Vermont | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-319-8452 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Washington | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-305-6759 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Wisconsin | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-524-9900 TTY 1-888-985-8775 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
West Virginia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 https://livantaqio.com/en/provider/transition	1-888-396-4646 TTY 1-888-985-2660 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays
Wyoming | KEPRO 5700 Lombardo CTR DR, STE 100 Seven Hills, OH 44131 https://www.keproqio.com/providers/transition	1-888-317-0891 TTY 1-855-843-4776 9 a.m. – 5 p.m. local time, Monday – Friday; 11 a.m. – 3 p.m. local time, weekends and holidays

SECTION 5 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 Part D drug coverage because they have a higher income. If you got 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 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	**1-800-772-1213** Calls to this number are free. Available 7:00 a.m. to 7:00 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	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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 about Medicaid and its programs, contact your state Medicaid agency.

State Medicaid Programs – Contact Information	
Alaska | State of Alaska Department of Health & Social Services, Division of Health Care Services 4501 Business Park BLVD, BLDG L Anchorage, AK 99503-2400 http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx	1-800-770-5650 TTY 1-907-465-5430
Alabama | Alabama Medicaid P.O. Box 5624 Montgomery, AL 36103-5624 http://www.medicaid.alabama.gov/	1-800-362-1504 TTY 711
Arkansas | Arkansas Division of Medical Services Department of Human Services Donaghey Plaza S, P.O. Box 1437 Slot S401 Little Rock, AR 72203-1437 https://medicaid.mmis.arkansas.gov	1-800-482-8988 TTY 1-800-285-1131
American Samoa | American Samoa Medicaid State Agency ASCTA Executive BLDG #304, P.O. Box 998383 Pago Pago, AS 96799 http://medicaid.as.gov/	1-684-699-4777 TTY 711
Arizona | Arizona Health Care Cost Containment System (AHCCCS) 801 E Jefferson Phoenix, AZ 85034 https://www.azahcccs.gov/	1-602-417-4000 TTY 1-800-367-8939
Arizona | Arizona Department of Economic Security/ Division of Developmental Disabilities (DDD) 1789 W Jefferson ST Phoenix, AZ 85007 https://www.azdes.gov/developmental_disabilities/	1-602-542-0419 TTY 711
California | Medi-Cal – Managed Care Operations Division Department of Health Care Services 1501 Capitol AVE, MS 4400 Sacramento, CA 95899 https://www.medi-cal.ca.gov/	1-916-636-1200 TTY 711
Colorado | Colorado Department of Health Care Policy and Financing 1570 Grant ST Denver, CO 80203-1818 https://www.healthfirstcolorado.com	1-800-221-3943 TTY 711
Connecticut | Connecticut Department of Social Services 55 Farmington AVE, P.O. Box 5005 Hartford, CT 06105-3730 https://www.ct.gov/hh	1-800-859-9889 TTY 1-800-842-4524

State Medicaid Programs – Contact Information	
District of Columbia | DC Department of Human Services 441 4th ST NW, STE 900-S Washington, DC 20001 https://dhs.dc.gov/service/medical-assistance	1-202-724-7491 TTY 711
Delaware | Delaware Health and Social Services 1901 N Dupont HWY, Lewis BLDG New Castle, DE 19720 http://dhss.delaware.gov/dhss/	1-800-372-2022 TTY 711
Florida | Florida Medicaid Agency for Health Care Administration (AHCA) 2727 Mahan DR, MS 6 Tallahassee, FL 32308 https://www.ahca.myflorida.com	1-888-419-3456 TTY 1-800-955-8771
Georgia | Georgia Department of Community Health 2 Peachtree ST NW Atlanta, GA 30303 https://medicaid.georgia.gov/	1-866-211-0950 TTY 711
Guam | Guam Department of Public Health and Social Services Bureau of Health Care Financing 123 Chalan Kareta Mangilao, GU 96913-6304 http://www.dphss.guam.gov/	1-671-735-7243 TTY 711
Hawaii | Department of Human Services 1390 Miller ST, RM 209 Honolulu, HI 96813 https://www.humanservices.hawaii.gov	1-808-586-5390 TTY 711
Iowa | Department of Human Services (Iowa Medicaid Enterprise) 1305 E Walnut ST Des Moines, IA 50319 http://dhs.iowa.gov/	1-800-338-8366 TTY 1-800-735-2942
Idaho | Idaho Department of Health and Welfare P.O. Box 70084 Boise, ID 83707 https://healthandwelfare.idaho.gov	1-866-686-4752 TTY 711
Illinois | Illinois Department of Healthcare and Family Services P.O. Box 92050 Elk Grove, IL 60009-2050 http://www2.illinois.gov/hfs/	1-866-329-4701 TTY 711
Indiana | Indiana Family and Social Services Administration 550 N Meridian ST, STE 101 Indianapolis, IN 46204 https://www.in.gov/medicaid/	1-877-647-4848 TTY 1-800-743-3333

State Medicaid Programs – Contact Information	
Kansas | KanCare (Kansas Department of Health and Environment) 900 SW Jackson STE 900 N Topeka, KS 66612-1220 https://www.kancare.ks.gov	1-866-305-5147 TTY 1-800-766-3777
Kentucky | Kentucky Cabinet for Health and Family Services 275 E Main ST Frankfort, KY 40621 https://chfs.ky.gov/	1-800-635-2570 TTY 711
Louisiana | Louisiana Department of Health 628 N 4th ST Baton Rouge, LA 70802 http://new.dhh.louisiana.gov/	1-225-342-9500 TTY 711
Massachusetts | Executive Office of Health and Human Services 1 Ashburton PL,5th FLR Boston, MA 02018 http://www.mass.gov/eohhs/gov/departments/masshealth/	1-888-665-9993 TTY 1-888-665-9997
Maryland | Maryland Department of Health 201 West Preston ST Baltimore, MD 21201 https://health.maryland.gov/pages/index.aspx	1-877-463-3464 TTY 1-800-735-2258
Maine | State of Maine Office of Mainecare Services 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms/	1-800-977-6740 TTY 711
Michigan | Department of Health and Human Services 333 S Grand AVE, P.O. Box 30195 Lansing, MI 48909 http://www.michigan.gov/mdhhs/	1-517-373-3740 TTY 1-800-649-3777
Minnesota | Minnesota Department of Human Services P.O. Box 64989 St. Paul, MN 55164-0989 http://mn.gov/dhs	1-800-657-3739 TTY 711
Missouri | MO HealthNet Division Department of Social Services 615 Howerton CT, P.O. Box 6500 Jefferson City, MO 65102 https://www.dss.mo.gov/mhd/	1-573-526-4274 TTY 1-800-735-2966
North Mariana Islands | State Medicaid Administration Office Government BLDG # 1252, Capital Hill RD, Caller Box 100007 Saipan, MP 96950 http://medicaid.cnmi.mp/	1-670-664-4880 TTY 711

State Medicaid Programs – Contact Information	
Mississippi | State of Mississippi Division of Medicaid 550 High ST STE, 1000 Sillers BLDG Jackson, MS 39201-1399 http://www.medicaid.ms.gov/	1-800-421-2408 TTY 711
Montana | Montana Healthcare Programs P.O. Box 254 Helena, MT 59624 https://dphhs.mt.gov/MontanaHealthcarePrograms	1-800-362-8312 TTY 1-800-833-8503
North Carolina | Division of Medical Assistance 2501 Mail Service CTR Raleigh, NC 27699-2501 https://dma.ncdhhs.gov/medicaid	1-800-662-7030 TTY 1-877-452-2514
North Dakota | North Dakota Department of Human Services 600 E BLVD AVE, Department 325 Bismarck, ND 58505-0250 http://www.nd.gov/dhs/services/medicalserv/medicaid	1-877-328-7098 TTY 1-800-366-6888
Nebraska | NE Department of Health and Human Services 301 Centennial Mall S Lincoln, NE 68509 http://dhhs.ne.gov/Pages/default.aspx	1-800-358-8802 TTY 711
New Hampshire | New Hampshire Department of Health and Human Services 129 Pleasant ST Concord, NH 03301 https://www.dhhs.nh.gov/ombp/medicaid/	1-603-271-4344 TTY 1-800-735-2964
New Jersey | Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625-0712 https://www.state.nj.us/humanservices/dmahs/	1-800-356-1561 TTY 711
New Mexico | NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504-2348 https://www.hsd.state.nm.us/mad/	1-888-997-2583 TTY 711
Nevada | Nevada Department of Health and Human Services 1100 E Williams ST, STE 101 Carson City, NV 89701 http://dhcfp.nv.gov	1-800-992-0900 TTY 711
New York | New York State Department of Health Corning Tower, Empire State Plaza Albany, NY 12237 http://www.health.state.ny.us/health_care/medicaid/index.htm	1-800-541-2831 TTY 711
Ohio | Ohio Department of Medicaid 50 W Town ST, STE 400 Columbus, OH 43215 https://medicaid.ohio.gov/	1-800-324-8680 TTY 711

State Medicaid Programs – Contact Information	
Oklahoma | Oklahoma Health Care Authority 4345 N Lincoln BLVD Oklahoma City, OK 73105 http://www.okhca.org	1-800-987-7767 TTY 711
Oregon | Oregon Health Authority P.O. Box 14015 Salem, OR 97309 https://www.oregon.gov/oha/HSD/OHP	1-800-273-0557 TTY 711
Pennsylvania | Pennsylvania Department of Human Services P.O. Box 2675 Harrisburg, PA 17105 http://www.dhs.pa.gov/	1-800-692-7462 TTY 1-800-451-5886
Puerto Rico | Government of Puerto Rico, Department of Health Medicaid Program P.O. Box 70184 San Juan, PR 00936-8184 https://medicaid.pr.gov	1-787-641-4224 TTY 1-787-625-6955
Rhode Island | Executive Office of Health and Human Services (EOHHS) 3 W RD Cranston, RI 02920 http://www.eohhs.ri.gov/	1-401-462-5274 TTY 711
South Carolina | South Carolina Department of Health and Human Services P.O. Box 100101 Columbia, SC 29203 http://www.scdhhs.gov/	1-888-549-0820 TTY 1-888-842-3620
South Dakota | South Dakota Department of Social Services, Division of Medical Services 700 Governors DR Pierre, SD 57501 http://dss.sd.gov/medicaid/	1-800-597-1603 TTY 711
Tennessee | Division of TennCare 310 Great Circle RD Nashville, TN 37243 https://www.tn.gov/tenncare/	1-800-342-3145 TTY 711
Texas | Texas Medicaid Health and Human Services Commission 4900 N Lamar BLVD Austin, TX 78751 https://hhs.texas.gov/about-hhs/find-us	1-512-424-6500 TTY 1-512-424-6597

State Medicaid Programs – Contact Information	
Utah | Utah Department of Health, Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 https://medicaid.utah.gov/	1-800-662-9651 TTY 711
Virginia | Department of Medical Assistance Services 600 E Broad ST Richmond, VA 23219 http://www.dmas.virginia.gov/	1-804-786-7933 TTY 711
Virgin Islands | U.S. Virgin Islands Bureau of Health Insurance & Medical Assistance 1303 Hospital Ground, Knud Hansen Complex BLDG A St. Thomas, VI 00802 http://www.dhs.gov.vi/financial_programs/medical_assistance.html	1-340-715-6929 TTY 711
Vermont | Department of Vermont Health Access 280 ST DR Waterbury, VT 05671 http://www.greenmountaincare.org/	1-800-250-8427 TTY 711
Washington | Washington State Health Care Authority P.O. Box 45502 Olympia, WA 98504-5502 https://www.hca.wa.gov/medicaid/Pages/index.aspx	1-800-562-3022 TTY 711
Wisconsin | Wisconsin Department of Health Services 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/health-care-coverage/index.htm	1-800-362-3002 TTY 711
West Virginia | West Virginia Bureau for Medical Services 350 Capitol ST, RM 251 Charleston, WV 25301 http://www.dhhr.wv.gov/bms/Pages/default.aspx	1-800-642-8589 TTY 711
Wyoming | Wyoming Department of Health 6101 Yellowstone RD, STE 210 Cheyenne, WY 82002 http://health.wyo.gov/healthcarefin/medicaid/	1-800-251-1269 TTY 1-855-329-5205

SECTION 7 Information about programs to help people pay for their 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 stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible and prescription copayments or coinsurance. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

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

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

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, your plan has established a process that allows you 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.

- Please call the customer service number in Chapter 2 Section 1. The Customer Service representative can help get your copayment amount corrected.
- When we receive the evidence showing your copayment level, we will update our 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. Either we will forward a check to you in the amount of your overpayment or we will 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 Customer Service if you have questions (phone numbers are printed on the back cover of this booklet).

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov for more information.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan may pay a portion of the costs of brand name drugs in the coverage gap. The 70% discount and any portion paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. **Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP office listed below.

AIDS Drug Assistance Program (ADAP) – Contact Information	
Alaska | Alaskan AIDS Assistance Association 1057 W Fireweed LN, #102 Anchorage, AK 99503 http://www.alaskanaids.org/index.php/client-services/adap	1-800-478-2437 9 a.m. – 5 p.m. local time, Monday – Friday
Alabama | Alabama AIDS Drug Assistance Program HIV/AIDS Division, 201 Monroe ST, STE 1400 Montgomery, AL 36104 http://www.alabamapublichealth.gov/hiv/adap.html	1-866-574-9964 8 a.m. – 5 p.m. local time, Monday – Friday
Arkansas | Arkansas Department of Health, Ryan White Program – Part B 4815 W Markham ST, Slot 33 Little Rock, AR 72205 https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-faqs	1-501-661-2408 8 a.m. – 4:30 p.m. local time, Monday – Friday
American Samoa | American Samoa Department of Health LBJ Tropical Medical CTR Pago Pago, AS 96799 https://www.americansamoa.gov/department-of-public-health	1-684-633-2437 8 a.m. – 5 p.m. local time, Monday – Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Arizona | Arizona Department of Health Services ADAP 150 N 18th AVE, STE 130 Phoenix, AZ 85007 https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home	1-800-334-1540 8 a.m. – 5 p.m. local time, Monday – Friday
California | Department of Health Services – ADAP P.O. Box 997426 Sacramento, CA 95899-7426 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_medpartd.aspx	1-844-421-7050 8 a.m. – 5 p.m. local time, Monday – Friday
Colorado | Colorado AIDS Drug Assistance Program (ADAP) ADAP-3800, 4300 Cherry Creek DR S Denver, CO 80246-1530 https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap	1-303-692-2716 9 a.m. – 5 p.m. local time, Monday – Friday
Connecticut | Connecticut ADAP Magellan Health Services P.O. Box 9971 Glen Allen, VA 23060 www.ctdph.magellanrx.com	1-800-424-3310 8 a.m. – 4 p.m. local time, Monday – Friday
District of Columbia | District of Columbia ADAP 899 N Capitol ST NE, STE 400 Washington, DC 20002 https://dchealth.dc.gov/node/137072	1-202-671-4815 8:15 a.m. – 4:45 p.m. local time, Monday – Friday
Delaware | Delaware Division of Public Health Ryan White Program 540 S DuPont HWY Dover, DE 19901 http://www.dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html	1-302-744-1050 8 a.m. – 4:30 p.m. local time, Monday – Friday
Florida | Florida Department of Health ADAP HIV/AIDS Section, 4052 Bald Cypress Way Tallahassee, FL 32399 http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	1-800-352-2437 8 a.m. – 9 p.m. local time, Monday – Friday
Georgia | Georgia AIDS Drug Assistance Program (ADAP) 2 Peachtree ST NW, FL 15 Atlanta, GA 30303-3186 http://dph.georgia.gov/adap-program	1-404-463-0416 8 a.m. – 5 p.m. local time, Monday – Friday
Guam | Bureau of Communicable Disease Control – STD/HIV 123 Chalan Kareta, RM 156 Mangilao, GU 96913 http://www.dphss.guam.gov/document/ryan-white-hivaids-program-brochure	1-671-734-2437 8 a.m. – 5 p.m. local time, Monday – Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Hawaii | HIV Drug Assistance Program (HDAP) 3627 Kilauea AVE, STE 306 Honolulu, HI 96816 http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/	1-808-733-9362 7:45 a.m. – 4:30 p.m. local time, Monday – Friday
Iowa | Iowa AIDS Drug Assistance Program (ADAP) 321 E 12th ST Des Moines, IA 50319-0075 https://www.idph.iowa.gov/hivstdhep/hiv/support	1-515-725-2011 8 a.m. – 4:30 p.m. local time, Monday – Friday
Idaho | Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, FL 4 Boise, ID 83720-0036 http://www.healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	1-208-334-5612 8 a.m. – 5 p.m. local time, Monday – Friday
Illinois | Illinois ADAP 525 W Jefferson ST, FL 1 Springfield, IL 62761 http://www.idph.state.il.us/health/aids/adap.htm	1-217-782-4977 8 a.m. – 5:30 p.m. local time, Monday – Friday
Indiana | Indiana HIV Medical Services Program 2 N Meridian ST Indianapolis, IN 46206 http://www.in.gov/isdh/17740.htm	1-866-588-4948 8 a.m. – 5 p.m. local time, Monday – Friday
Kansas | Kansas AIDS Drug Assistance Program 1000 SW Jackson, STE 210 Topeka, KS 66612 http://www.kdheks.gov/sti_hiv/ryan_white_care.htm	1-785-296-6174 8 a.m. – 5 p.m. local time, Monday – Friday
Kentucky | Kentucky AIDS Drug Assistance Program (KADAP) HIV/AIDS Branch, 275 E Main ST, HS2E-C Frankfort, KY 40621 https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	1-502-564-6539 8 a.m. – 5 p.m. local time, Monday – Friday
Louisiana | Louisiana Office of Public Health STD/HIV Program, 1450 Poydras ST, STE 2136 New Orleans, LA 70112 http://new.dhh.louisiana.gov/index.cfm/page/1099	1-504-568-7474 8 a.m. – 5 p.m. local time, Monday – Friday
Massachusetts | Community Research Initiative/HDAP The Schrafft's City CTR, 529 Main ST, STE 301 Charlestown, MA 02129 http://crine.org/hdap/	1-617-502-1700 8 a.m. – 5 p.m. local time, Monday – Friday
Maryland | Maryland AIDS Drug Assistance Program 201 W Preston ST Baltimore, MD 21201 https://phpa.health.maryland.gov/OIDPCS/CHCS/Pages/madap.aspx	1-410-767-6535 8:30 a.m. – 4:30 p.m. local time, Monday – Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Maine | Maine AIDS Drug Assistance Program 11 State House Station, 286 Water ST Augusta, ME 04330 http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/aids-drug-assist.shtml	1-207-287-3747 8 a.m. – 5 p.m. local time, Monday – Friday
Michigan | Michigan Drug Assistance Program HIV Care Section, 109 Michigan AVE, FL 9 Lansing, MI 48913 http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982_70541_70542—,00.html	1-888-826-6565 8 a.m. – 5 p.m. local time, Monday – Friday
Minnesota | Minnesota HIV/AIDS Programs Department of Human Services, P.O. Box 64972 St. Paul, MN 55164-0972 http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/contact-us/index.jsp	1-800-657-3761 8:30 a.m. – 4:30 p.m. local time, Monday – Friday
Missouri | Missouri Department of Health and Senior Services Bureau of HIV, STD and Hepatitis, P.O. Box 570 Jefferson City, MO 65102-0570 http://health.mo.gov/living/healthcondiseases/communicable/hivaids/index.php	1-573-751-6439 8 a.m. – 5 p.m. local time, Monday – Friday
Mississippi | Mississippi Department of Health, STD/HIV Office 570 E Woodrow Wilson DR, P.O. Box 1700 Jackson, MS 39215-1700 http://msdh.ms.gov/msdhsite/_static/14,0,150.html	1-601-576-7723 8 a.m. – 5 p.m. local time, Monday – Friday
Montana | Montana AIDS Drug Assistance Program (ADAP) DPHHS, Cogswell BLDG C-211, 1400 Broadway ST Helena, MT 59620-2951 http://dphhs.mt.gov/publichealth/hivstd/treatmentprogram.aspx	1-406-444-3565 8 a.m. – 5 p.m. local time, Monday – Friday
North Carolina | North Carolina HIV/STD Prevention and Care Unit Communicable Disease Branch, 1905 Mail Service CTR Raleigh, NC 27699-1905 http://epi.publichealth.nc.gov/cd/hiv/adap.html	1-919-733-3419 8 a.m. – 5 p.m. local time, Monday – Friday
North Dakota | North Dakota Department of Health, HIV/AIDS Program 2635 E Main AVE Bismarck, ND 58506-5520 https://www.ndhealth.gov/hiv/RyanWhite/	1-800-472-2180 8 a.m. – 5 p.m. local time, Monday – Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Nebraska | Nebraska Department of Health & Human Services Ryan White HIV/AIDS Program, 301 Centennial Mall S Lincoln, NE 68509 http://dhhs.ne.gov/Pages/HIV-Prevention.aspx	1-402-471-3121 8 a.m. – 5 p.m. local time, Monday – Friday
New Hampshire | New Hampshire CARE Program 129 Pleasant ST Concord, NH 03301 https://www.dhhs.nh.gov/dphs/bchs/std/care.htm	1-603-271-4502 8 a.m. – 4:30 p.m. local time, Monday – Friday
New Jersey | New Jersey AIDS Drug Distribution Program (ADDP) P.O. Box 360 Trenton, NJ 08625-0360 http://www.state.nj.us/health/hivstdtb/hiv-aids/medications.shtml	1-877-613-4533 8 a.m. – 4:30 p.m. local time, Monday – Friday
New Mexico | New Mexico Department of Health – Infectious Disease Bureau 1190 S Saint Francis DR, STE 1200 Santa Fe, NM 87505 http://nmhealth.org/about/phd/idb/hats/	1-505-827-2435 8 a.m. – 5 p.m. local time, Monday – Friday
Nevada | Nevada Office of HIV/AIDS 4126 Technology Way, STE 200 Carson City, NV 89706 http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/	1-775-684-3499 8 a.m. – 5 p.m. local time, Monday – Friday
New York | New York AIDS Drug Assistance Program HIV Uninsured Care Programs, Empire STA, P.O. Box 2052 Albany, NY 12220-0052 http://www.health.ny.gov/diseases/aids/general/resources/adap/	1-800-542-2437 8 a.m. – 5 p.m. local time, Monday – Friday
Ohio | Ohio HIV Drug Assistance Program (OHDAP) HIV Care Services Section, 246 N High ST Columbus, OH 43215 https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/ryan-white-part-b-hiv-client-services/welcome-to	1-614-466-6374 8 a.m. – 5 p.m. local time, Monday – Friday
Oklahoma | Oklahoma HIV/STD Services Division Oklahoma Department of Health, 1000 NE Tenth Oklahoma City, OK 73117 https://www.ok.gov/health/Disease,_Prevention,_Preparedness/HIV_STD_Service/Care_Delivery_(Ryan_White_ADAP_Hepatitis)/index.html	1-405-271-4636 8 a.m. – 5 p.m. local time, Monday – Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Oregon | Oregon CAREAssist 800 NE Oregon ST, STE 1105 Portland, OR 97232 http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx	1-971-673-0144 8 a.m. – 5 p.m. local time, Monday – Friday
Pennsylvania | Pennsylvania Special Pharmaceutical Benefits Program Department of Health, 625 Forster S, H&W BLDG, RM 611 Harrisburg, PA 17120 https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx	1-800-922-9384 8 a.m. – 4:30 p.m. local time, Monday – Friday
Puerto Rico | Puerto Rico Departmento de Salud, Programa Ryan White Parte B P.O. Box 70184 San Juan, PR 00936-8184 http://www.salud.gov.pr/Dept-de-Salud/Pages/Directorio.aspx	1-787-765-2929 8 a.m. – 4:30 p.m. local time, Monday – Friday
Rhode Island | Rhode Island AIDS Drug Assistance Program Department of Health, 3 Capitol Hill Providence, RI 02908 http://health.ri.gov/diseases/hivaids/about/stayinghealthy/	1-401-222-5960 8:30 a.m. – 4:30 p.m. local time, Monday – Friday
South Carolina | South Carolina AIDS Drug Assistance Program (ADAP) DHEC, STD/HIV Division, 2600 Bull ST Columbia, SC 29201 http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/	1-800-856-9954 8 a.m. – 5 p.m. local time, Monday – Friday
South Dakota | Ryan White Part B CARE Program South Dakota Department of Health, 615 E 4th ST Pierre, SD 57501-1700 http://doh.sd.gov/diseases/infectious/ryanwhite/	1-800-592-1861 8 a.m. – 5 p.m. local time, Monday – Friday
Tennessee | Tennessee HIV Drug Assistance Program (HDAP) Department of Health, 710 James Robertson PKWY Nashville, TN 37243 https://www.tn.gov/health/health-program-areas/std/std/ryanwhite.html	1-615-741-7500 8 a.m. – 4:30 p.m. local time, Monday – Friday
Texas | Texas HIV Medication Program ATTN: MSJA, MC 1873, P.O. Box 149347 Austin, TX 78714-9387 www.dshs.state.tx.us/hivstd/meds	1-800-255-1090 8 a.m. – 5 p.m. local time, Monday – Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Utah | Utah Department of Health, Bureau of Epidemiology 288 N 1460 W, P.O. Box 142104 Salt Lake City, UT 84114-2104 http://health.utah.gov/epi/treatment/	1-801-538-6197 8 a.m. – 5 p.m. local time, Monday – Friday
Virginia | Virginia AIDS Drug Assistance Program (ADAP) Office of Disease Prevention, 109 Governor ST, FL 6 Richmond, VA 23219 http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/	1-855-362-0658 8 a.m. – 5 p.m. local time, Monday – Friday
Virgin Islands | US Virgin Islands STD/HIV/TB Program USVI Department of Health, Old Municipal Hospital Complex, BLDG 1 St. Thomas, VI 00802 https://doh.vi.gov/programs/communicable-diseases	1-340-774-9000 8 a.m. – 5 p.m. local time, Monday – Friday
Vermont | VT Medication Assistance Program Health Surveillance Division, P.O. Box 70 Burlington, VT 05402 http://healthvermont.gov/prevent/aids/aids_index.aspx	1-802-863-7638 7:45 a.m. – 4:30 p.m. local time, Monday – Friday
Washington | Washington Early Intervention Program (EIP) HIV Client Services, P.O. Box 47841 Olympia, WA 98504-7841 https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP	1-877-376-9316 8 a.m. – 5 p.m. local time, Monday – Friday
Wisconsin | Wisconsin AIDS Drug Assistance Program (ADAP) Department of Health Services, 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/aids-hiv/adap.htm	1-800-991-5532 8 a.m. – 5 p.m. local time, Monday – Friday
West Virginia | West Virginia AIDS Drug Assistance Program (ADAP) 350 Capitol ST, RM 125 Charleston, WV 25301 https://oeps.wv.gov/aboutus/Pages/about_dsh.aspx	1-800-642-8244 8 a.m. – 4 p.m. local time, Monday – Friday
Wyoming | Wyoming Department of Health Communicable Disease Unit HIV Treatment Program, 401 Hathaway BLDG Cheyenne, WY 82002 https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/	1-307-777-7579 8 a.m. – 5 p.m. local time, Monday – Friday

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next **Part D Explanation of Benefits** (Part D EOB) notice. If the discount doesn't appear on your **Part D Explanation of Benefits**, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members. Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:

- California – Department of Health Services – ADAP
- Colorado – Colorado CDPHE State Drug Assistance Program (SDAP)
- Connecticut – Connecticut AIDS Drug Assistance Program (CADAP)
- District of Columbia – District of Columbia Department of Health
- Delaware – Delaware Prescription Assistance Program
- Guam – Guam Medically Indigent Program (MIP)
- Idaho – Idaho AIDS Drug Assistance Program (IDADAP)
- Indiana – HoosierRx
- Louisiana – Louisiana Department of Health
- Massachusetts – Prescription Advantage Executive Office of Elder Affairs
- Maryland – Maryland Senior Prescription Drug Assistance Program (SPDAP)
- Maine – MaineCare Services
- Missouri – MissouriRx Plan (MORx)
- Montana – Montana Big Sky Rx
- New Jersey – New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD)
- Nevada – Nevada Senior/Disability Rx Program
- New York – New York State EPIC Program
- Pennsylvania – Pennsylvania PACE
- Rhode Island – Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)

- Texas – Texas HIV State Pharmaceutical Assistance Program (SPAP)
- Virginia – Virginia Medication Assistance Program (MAP
- Virgin Islands – US Virgin IslandsPharmaceutical Assistance Program
- Vermont – Green Mountain Care Prescription Assistance
- Wisconsin – Wisconsin SeniorCare Pharmaceutical Assistance Program

State Pharmaceutical Assistance Programs – Contact Information	
California | Department of Health Services – ADAP P.O. Box 997377 Sacramento, CA 95899-7377 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx	1-844-421-7050 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday
Colorado | Colorado CDPHE State Drug Assistance Program (SDAP) SDAP-3800, 4300 Cherry Creek DR S Denver, CO 80246-1530 https://www.colorado.gov/pacific/cdphe/state-drug-assistance-program	1-303-692-2716 TTY 711 9 a.m. – 5 p.m. local time, Monday – Friday
Connecticut | Connecticut AIDS Drug Assistance Program (CADAP) c/o Magellan Health, 15 Cornell RD, STE 2201 Lathan, NY 12110 https://ctdph.magellanrx.com/	1-800-424-3310 TTY 711 8 a.m. – 4 p.m. local time, Monday – Friday
District of Columbia | District of Columbia Department of Health AIDS Drug Assistance Program (ADAP) 899 N Capitol ST NE Washington, DC 20002 https://dchealth.dc.gov/node/137072	1-202-671-4815 TTY 711 8:15 a.m. – 4:45 p.m. local time, Monday – Friday
Delaware | Delaware Prescription Assistance Program PO BOX 950, MANOR BRANCH New Castle, DE 19720 https://dhss.delaware.gov/dhss/dmma/dpap.html	1-844-245-9580 TTY 711 8 a.m. – 4:30 p.m. local time, Monday – Friday
Guam | Guam Medically Indigent Program (MIP) Bureau of Economic Security, 520 West Santa Monica Avenue Dededo, GU 95929 http://dphss.guam.gov/bureau-of-economic-security/	1-671-635-7432 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday
Idaho | Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, P.O. Box 83720 Boise, ID 83720-0036 http://www.healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	1-208-334-6657 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday

State Pharmaceutical Assistance Programs – Contact Information	
Indiana | HoosierRx P.O. Box 6224 Indianapolis, IN 49206 https://www.in.gov/medicaid/members/194.htm	1-866-267-4679 TTY 711 8 a.m. – 4:30 p.m. local time, Monday – Friday
Louisiana | Louisiana Department of Health Medicare Savings Program, P.O. Box 629 Baton Rouge, LA 70802 http://dhh.louisiana.gov/index.cfm/page/236	1-888-544-7996 TTY 711 8 a.m. – 4:30 p.m. local time, Monday – Friday
Massachusetts | Prescription Advantage Executive Office of Elder Affairs P.O. Box 15153 Worcester, MA 01615-0153 https://www.prescriptionadvantagema.org/	1-800-243-4636 TTY 1-877-610-0241 9 a.m. – 5 p.m. local time, Monday – Friday
Maryland | Maryland Senior Prescription Drug Assistance Program (SPDAP) c/o Pool Administrators, 628 Hebron AVE, STE 502 Glastonbury, CT 06033 www.marylandspdap.com	1-800-551-5995 TTY 1-800-877-5156 8 a.m. – 5 p.m. local time, Monday – Friday
Maine | MaineCare Services 11 State House Station Augusta, ME 04333-0011 http://www.maine.gov/dhhs/oms/member/index.shtml	1-800-977-6740 TTY 711 7 a.m. – 6 p.m. local time, Monday – Friday
Missouri | MissouriRx Plan (MORx) P.O. Box 6500 Jefferson City, MO 65102-6500 www.morx.mo.gov	1-800-375-1406 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday
Montana | Montana Big Sky Rx P.O. Box 202915 Helena, MT 59620-2915 www.bigskyrx.mt.gov	1-866-369-1233 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday
New Jersey | New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD) P.O. Box 715 Trenton, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/paad/	1-800-792-9745 TTY 711 8:30 a.m. – 4:30 p.m. local time, Monday – Friday

State Pharmaceutical Assistance Programs – Contact Information	
Nevada | Nevada Senior/Disability Rx Program 1860 E. Sahara AVE Las Vegas, NV 89104 http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/	1-866-303-6323 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday
New York | New York State EPIC Program P.O. Box 15018 Albany, NY 12212-5018 http://www.health.ny.gov/health_care/epic/	1-800-332-3742 TTY 1-800-290-9138 8:30 a.m. – 5 p.m. local time, Monday – Friday
Pennsylvania | Pennsylvania PACE P.O. Box 8806 Harrisburg, PA 17105-8806 https://pacecares.magellanhealth.com	1-800-225-7223 TTY 1-800-222-9004 8:30 a.m. – 5 p.m. local time, Monday – Friday
Rhode Island | Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) 57 Howard AVE, Louis Pasteur BLDG, FL 2 Cranston, RI 02920 http://www.dea.ri.gov/programs/prescription_assist.php	1-401-462-3000 TTY 1-401-462-0740 8:30 a.m. – 4 p.m. local time, Monday – Friday
Texas | Texas HIV State Pharmaceutical Assistance Program (SPAP) P.O. Box 149347, MC 1873 Austin, TX 78714 https://www.dshs.state.tx.us/hivstd/meds/spap.shtm	1-800-255-1090 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday
Virginia | Virginia Medication Assistance Program (MAP) P.O. Box 2448 Richmond, VA 23218-2448 http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/	1-855-362-0658 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday
Virgin Islands | US Virgin IslandsPharmaceutical Assistance Program 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 http://www.dhs.gov.vi/seniors/pharmaceutical.html	1-340-774-0930 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday
Vermont | Green Mountain Care Prescription Assistance Department of Vermont Health Access, 280 State DR Waterbury, VT 05671-1020 http://www.greenmountaincare.org/perscription	1-800-250-8427 TTY 711 8 a.m. – 5 p.m. local time, Monday – Friday

State Pharmaceutical Assistance Programs – Contact Information	
Wisconsin | Wisconsin SeniorCare Pharmaceutical Assistance Program Department of Health Services, 1 W Wilson ST, P.O. Box 6710 Madison, WI 53716-0710 http://www.dhs.wisconsin.gov/seniorcare	1-800-657-2038 TTY 711 8 a.m. – 6 p.m. local time, Monday – Friday

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board — Contact Information
CALL	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
WEBSITE	rrb.gov/

SECTION 9 Do you have other "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group other than ERS as part of this plan, you may call the employer benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage 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 our plan.

Chapter 3

Using the plan's coverage for your Part D prescription drugs

Chapter 3

Using the plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you**. We sent you 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 don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter **explains rules for using your coverage for Part D drugs**. The next chapter tells what you pay for Part D drugs (Chapter 4, **What you pay for your Part D prescription drugs**).

In addition to your coverage for Part D drugs through our plan, 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 2021 Handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist 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 the 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 should use a network pharmacy to fill your prescription. (See Section 2, **Fill your prescription at a network pharmacy or through the plan's mail order service**.)

- Your drug must be on the plan's List of Covered Drugs (Formulary) (we call it the "Drug List" for short). (See Section 3, **Your drugs need to be on the plan's "Drug List".**) To get the most current information, visit the plan's website (www.HSMedicareRx.com).
- 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 or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered **only** if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Pharmacy Directory**, visit our website (www.HSMedicareRx.com) or call Customer Service (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy. You should use a network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on the back cover of this booklet) or use the **Pharmacy Directory**. You can also find information on our website at www.HSMedicareRx.com.

What if you need a specialized pharmacy?

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, a long-term care 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 Customer Service.

- 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 Customer Service (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail order services

Our plan's mail order service allows you to order **up to a 90-day supply** of drugs on the HealthSelect Medicare Rx Maintenance Drug List.

To get order forms and information about filling your prescriptions by mail, please reference your Pharmacy Directory to find the mail service pharmacies in our network. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail order pharmacy order will get to you in no more than 10 business days. However, sometimes your mail order may be delayed. If your mail order is delayed, please follow these steps:

If your prescription is on file at your local pharmacy, go to your pharmacy to fill the prescription. If your delayed prescription is not on file at your local pharmacy, then please ask your doctor to call in a new prescription to your pharmacist. Or, your pharmacist can call the doctor's office for you to request the prescription. Your pharmacist can call the Pharmacy help desk at **(855) 798-5675** (**TTY: 711**), 24 hours a day, 7 days a week if he/she has any problems, questions, concerns, or needs a claim override for a delayed prescription.

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by phone or mail.

However, if you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by phone or mail.

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. 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 you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by phone or mail.

Refills on mail order prescriptions. For refills, please contact your pharmacy at least 10 business 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. You also have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. To cancel the auto refill program, please contact the mail order pharmacy 10 days before your order will ship or you can let the pharmacy know when they notify you of an upcoming shipment. Please keep your mail order pharmacy informed about the best way(s) to contact you, so the pharmacy can reach you to confirm your order before shipping. You can do this by contacting the mail order pharmacy when you set up your auto refill program and also when you receive notifications about upcoming refill shipments.

Section 2.4 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. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on the HealthSelect Medicare Rx Maintenance Drug List. You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. Some participating retail pharmacies are part of the Extended Day Supply (EDS) network and will fill a long-term supply (31–90-day supply) of maintenance drugs at the same price as the plan's mail order pharmacy.
2. You can use the plan's network **mail order service**. Our plan's mail order service allows you to order **up to a 90-day supply** of drugs. See Section 2.3 for more information about using our mail order services.

Section 2.5 Using a pharmacy that is not in the plan's network

Your prescription may be covered in certain situations
Your cost may be greater if you use an out-of-network pharmacy to fill your prescription. If you use an out-of-network pharmacy, you must submit a paper claim in order to be reimbursed.

How do you ask for reimbursement from the plan?

Your cost may be greater if you use an out-of-network pharmacy to fill your prescription. If you use an out-of-network pharmacy, you must submit a paper claim in order to be reimbursed. 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 our share of the cost. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan 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 the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs). However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit the plan's website at www.HSMedicareRx.com or call Customer Service.

We will generally cover a drug on the plan's 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, such as 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.

What is not on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are 3 "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of 3 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1: Preferred Generic — All covered generic drugs.
- Tier 2: Preferred Brand — Many common brand name drugs, called preferred brands.
- Tier 3: Non-preferred Drug — Non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 3.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 **(What you pay for your Part D prescription drugs)**.

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have two ways to find out:

1. Visit the plan's website (www.HSMedicareRx.com) for the most current information.
2. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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 members 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, our 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, the plan'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 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 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. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our 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 health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan 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 you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan 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 you can have by limiting 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.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan'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 Customer Service (phone numbers are printed on the back cover of this booklet) or check our website (www.HSMedicareRx.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 Customer Service 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. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking, that is not on our drug list (formulary) or is on our formulary with restrictions. 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.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan 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.
- 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. The plan puts each covered drug into one of 3 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 that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

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 members 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 the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan 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 plan's Drug List.**
   - — or — the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).
2. **You must be in one of the situations described below:**
   - **For those members who are new or who were in the plan last year:**
     We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the plan year if you were in the plan last year**. This temporary supply will be for at least a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to at least a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
   - **For those members 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 at least a 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
   - **For those current members with level of care changes:**
     There may be unplanned transitions such as hospital discharges or level of care changes that occur while you are enrolled as a member in our plan. If you are prescribed a drug that is not on our Drug List or your ability to get your drugs is limited, you are required to use the plan's exception process. You may request a one-time temporary supply of at least 30 days to allow you time to discuss alternative treatment with your doctor or to pursue a drug list (formulary) exception. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 30-day supply.

To ask for a temporary supply, call Customer Service (phone numbers are printed on the back cover of this booklet).

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 the plan or ask the plan 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 the plan that might work just as well for you. You can call Customer Service 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 Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan 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 the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing 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 Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan 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.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

We do not lower the cost-sharing level for high cost specialty drugs.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each plan year. However, during the year, the plan might make changes to the Drug List. For example, the plan 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** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our website on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Customer Service for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below 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 or both)**
  - 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 or both.
  - 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 7 (**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 we cover.
- Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 7 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).

Changes to drugs on the Drug List that will not 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 you stay in the plan:

- 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 Drug List in the new benefit year for any changes to drugs.

SECTION 7 What types of drugs are not covered by the plan?

Section 7.1 Types of drugs we do not cover

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. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7, Section 5.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System. If the use is not supported by any of these references, then our plan 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
- 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

Please note: ERS may have elected to offer some of the drugs listed above to you as an additional benefit. If so, you will receive additional information about the drugs they have chosen to offer to you separately, in your plan materials.

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. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Show your UnitedHealthcare member ID card when you fill a prescription

Section 8.1 Show your UnitedHealthcare member ID card

To fill your prescription, show your UnitedHealthcare member ID card at the network pharmacy you choose. When you show your UnitedHealthcare member ID card, the network pharmacy will automatically bill the plan for **our** share of your covered prescription drug cost. You will need to pay the pharmacy **your** share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your UnitedHealthcare member ID card with you?

If you don't have your UnitedHealthcare member ID card with you when you fill your prescription, ask the pharmacy to call the plan 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. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?

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, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about 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, your plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 8, **Ending your membership in the plan**, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (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 a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your Pharmacy Directory to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service (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 member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership. The total supply will be for at least a 31-day supply. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 31-day supply. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover at least a 31-day supply. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 31-day supply.

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 by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in HealthSelect Medicare Rx 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 Part D plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan 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 HealthSelect Medicare Rx in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or HealthSelect Medicare Rx for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or another retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or another retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the retiree group prescription drug coverage you get from us will be **secondary** to coverage through your current employer.

Special note about "creditable coverage":

If you have other prescription drug coverage, each plan year that group's benefit administrator should send you a notice that tells if your prescription drug coverage for the next plan year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage you can get a copy from your former employer or retiree group's benefits administrator or your former employer.

Section 9.6 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our 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, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, 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, our plan 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 tell about the rules for getting drug coverage under Part D. Chapter 4 (**What you pay for your Part D prescription drugs**) gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members 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
- Unsafe amounts of opioid pain medications

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

Section 10.2 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 their prescription opioid medications, and other medications that are frequently abused. 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 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 terms of 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 7 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.

Section 10.3 Medication Therapy Management (MTM) programs to help members manage their medications

We have programs that can help our members with complex health needs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members get the most benefit from the drugs they take. One program is called a Medication Therapy Management (MTM) program.

Some members who take medications for different medical conditions and have high drug costs may be able to get services through a MTM program. 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, and any problems or questions you have about your prescription and over-the-counter medications. 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 have 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 health care providers. Also, keep your medication list with you (for example, with your ID) in case 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 Customer Service (phone numbers are printed on the back cover of this booklet).

Chapter 4

What you pay for your Part D prescription drugs

Chapter 4

What you pay for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We sent you 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 don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. Your Plan Sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. **Section 5.2 of this chapter contains a table that shows your costs for a drug** that is covered by both your Part D prescription drug benefit and your supplemental drug coverage. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs — 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 plan's 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 3 "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 Customer Service (phone numbers are printed on the back cover of this booklet). You can also find the most current information on our website at www.HSMedicareRx.com.
- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.

- **The plan's Pharmacy Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The Pharmacy Directory has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost sharing," and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for our plan members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. 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	Stage 2	Stage 3	Stage 4
Yearly Deductible Stage	**Initial Coverage Stage**	**Coverage Gap Stage**	**Catastrophic Coverage Stage**
You begin in this payment stage when you fill your first prescription of the year. During this stage, **you pay the full cost of** your drugs. You stay in this stage until you have paid $50 for your drugs ($50 is the amount of your deductible). (Details are in Section 4 of this chapter.)	During this stage, the plan 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 **"total drug costs"** (your payments plus any Part D plan's payments) total $4,130. (Details are in Section 5 of this chapter.)	The plan continues to pay 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 a total of $6,550. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, you will continue to pay the same cost share that you paid in the Initial Coverage Stage for the rest of the plan year. (Details are in Section 7 of this chapter.)

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan 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. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **"out-of-pocket"** cost.
- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the Part D Explanation of Benefits (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. 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. It includes:

- **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 the plan paid, and what you and others on your behalf paid.
- **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.

Section 3.2 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 UnitedHealthcare member ID 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 UnitedHealthcare member ID 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. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) 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 our plan'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 (a Part D 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 us at Customer Service (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.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Section 4.1 You stay in the Deductible Stage until you have paid your deductible

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you pay the full cost of your drugs** until you reach your deductible amount.

- Your "**full cost**" is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The "**deductible**" is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid your deductible, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

Your plan has a deductible of $50. However, your deductible will be different if you receive Medicare's "Extra Help" with your prescription drug costs. Depending on the level of Extra Help you receive, your deductible will be $0 or $92.

You will get a Low Income Subsidy Rider, or LIS Rider, in a separate mailing. It explains Extra Help and tells you the amount of your deductible.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 3 cost-sharing tiers

Every drug on the plan's Drug List is in one of 3 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

- Tier 1: Preferred Generic — All covered generic drugs
- Tier 2: Preferred Brand — Many common brand name drugs, called preferred brands.
- Tier 3: Non-preferred Drug — Non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 3.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in our plan's network
- A retail pharmacy that is in our plan's Extended Day Supply (EDS) network
- A pharmacy that is not in the plan's network
- The plan's mail order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and the plan's **Pharmacy Directory**.

Section 5.2 A table that shows your costs for a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be a copayment.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.

As shown in the tables below, the amount of the copayment depends on which cost-sharing tier your drug is in. Please note:

- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (for details on where and how to get a long-term supply of a drug, see Chapter 3.)

The table below shows what you pay when you get a 30-day supply at a retail pharmacy and a 31- to 60-day supply and a 61 to 90-day supply of drugs in the Extended Days Supply (EDS) Network.

Your share of the cost when you get a covered Part D prescription drug from:				
	Retail Cost-Sharing		**Retail Cost Share in the Extended Days Supply (EDS) Network**	
Tier	**(30-day supply of non-maintenance drugs)**	**(30-day supply of maintenance drugs*)**	**(31- to 60-day supply)**	**(61- to 90-day supply)**
Cost-Sharing Tier 1 Preferred Generic	$10 copayment	$10 copayment	$20 copayment	$30 copayment
Cost-Sharing Tier 2 Preferred Brand	$35 copayment	$45 copayment	$70 copayment	$105 copayment
Cost-Sharing Tier 3 Non-preferred Drug	$60 copayment	$75 copayment	$120 copayment	$180 copayment

*Please see Additional Prescription Drug Coverage for a list of the plan's maintenance drugs.

The table below shows what you pay when you get a 31-day to 60-day supply and a 61- to 90-day supply of drugs from the plan's mail order pharmacy.

Your share of the cost when you get a covered Part D prescription drug from:		
Mail Order Cost-Sharing		
Tier	**(31- to 60-day supply)**	**(61- to 90-day supply)**
Cost-Sharing Tier 1 Preferred Generic	$20 copayment	$30 copayment
Cost-Sharing Tier 2 Preferred Brand	$70 copayment	$105 copayment
Cost-Sharing Tier 3 Non-preferred Drug	$120 copayment	$180 copayment

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. 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 your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
  - Here's an example: Let's say the copayment for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure certain drugs work 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 dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,130

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the $4,130 limit for the Initial Coverage Stage.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The $50 you paid when you were in the Deductible Stage.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2021, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The Part D **Explanation of Benefits** (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $4,130 limit in a year.

We will let you know if you reach this $4,130 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $6,550

ERS is providing supplemental coverage that is keeping your copayments consistent through the Coverage Gap, therefore you will see no change in copayments until you qualify for Catastrophic Coverage.

After your total drug costs reach $4,130, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.

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

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments are included in your out-of-pocket costs

When you add up your out-of-pocket costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages.
  - The Deductible Stage.
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- 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.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not 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 plan year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage. The catastrophic coverage will go towards Part D covered medications.

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:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.

- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are 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 our plan. Call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The **Part D Explanation of Benefits** (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report).
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

When your out-of-pocket costs reach the $6,550 limit for the plan year, you move to the Catastrophic Coverage Stage. In this stage, you will continue to pay the same cost share that you paid in the Initial Coverage Stage.

The catastrophic coverage will go towards Part D covered medications.

SECTION 8 Additional benefits information

Section 8.1 Your plan has benefit limitations

This part of Chapter 4 talks about limitations of your plan.

1. Early refills for lost, stolen or destroyed drugs are not covered except during a declared "National Emergency."
2. Early refills for vacation supplies are limited to a one-time fill of up to 30 days per calendar year.
3. Medications will not be covered if prescribed by physicians or other providers who are excluded or precluded from the Medicare program participation.
4. You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days supply.
5. Costs for drugs that are not covered under Part D do not count toward your out-of-pocket costs.

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage for a number of Part D vaccines. There are two parts to our coverage of Part D 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 vaccine**. (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 considered Part D drugs. You can find these vaccines listed in the plan's **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 vaccine

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 vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, 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 vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine 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 copayment and/or coinsurance for the vaccine and the cost of giving you the vaccine.
- Our plan 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 our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet **(Asking us to pay our share of the costs for covered drugs)**.
- You will be reimbursed the amount you paid less your normal copayment 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 vaccine.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.
- 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. (If you get "Extra Help," we will reimburse you for this difference.)

Section 9.2 You may want to call us at Customer Service 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 at Customer Service, whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by your plan and explain your share of the cost.

- We can tell you how to keep your own cost down by using providers and pharmacies in our 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 us for our share of the cost.

Chapter 5

Asking us to pay our share of the costs for covered drugs

Chapter 5

Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

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 the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

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.

   - Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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 plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan 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 us to pay you back for our share of the cost.

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 yet be on the plan's 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 pay you back for our share of the cost.

4. **If you are retroactively enrolled in our plan.**

   Sometimes a person's enrollment in the plan 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 our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement. Submit claims no later than 36 months from the date of the service.

   Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet).

   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. Chapter 7 of this booklet **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, 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.

Mail your request for payment together with any receipts to us. See Chapter 2 for the address.

You must submit your Part D (prescription drug) claim to us within 36 months of the date you received the drug.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). 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.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

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 pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs

covered.) We will send payment 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 pay for our share of the cost. 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.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

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.

For the details on how to make this appeal, go to Chapter 7 of this booklet (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**). 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 Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. **When you buy the drug for a price that is lower than our price**

   Sometimes when you are in the Deductible Stage, you can buy your drug **at a network pharmacy** for a price that is lower than our price.

   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
   - Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- **Please note:** If you are in the Deductible Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 6

Your rights and responsibilities

Chapter 6

Your rights and responsibilities

SECTION 1 Your plan must honor your rights as a member of the plan

Section 1.1 You have a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

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

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's 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 Customer Service (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) 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 Customer Service for additional information.

Section 1.2 We must ensure that you get timely access to your covered drugs

As a member of our Plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.3 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," that 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 member of our plan through Medicare, 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 the plan, 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 health care 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 Customer Service (phone numbers are printed on the back cover of this booklet).

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2021

We[1] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice.

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[1]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MD - Individual Practice Association, Inc.; Medica Health Plans of Florida, Inc.; Medica Healthcare Plans, Inc.; National Pacific Dental, Inc.; National Foundation Life Insurance Company; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Peoples Health, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; Symphonix Health Insurance, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance

Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, www.HSMedicareRx.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care

coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us. We may communicate certain health information in these messages via unencrypted methods. These communications may be sent unencrypted and there is some risk of disclosure or interception of the contents of these communications.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law,

such as licensure, governmental audits and fraud and abuse investigations.

- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS

7. Mental Health
8. Minors' Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed

below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website, www.HSMedicareRx.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, **please call the toll-free member phone number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at (866) 868-0609 (TTY/RTT 711).**
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:
  UnitedHealthcare Privacy Office
  P.O. Box 1459
  Minneapolis, MN 55440
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2021

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, **please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at (866) 868-0609 (TTY/RTT 711).**

[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Corporation.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; Managed Physical Network, Inc.; Medication Management dba Genoa Medication Management Solutions; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, Inc.; Optum Networks of New Jersey, Inc.; Optum Women's and Children's Health, LLC; OrthoNet, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Renai Health IPA, LLC' Renai Health Management, LLC; Sanvello Health, Inc.; Savvysherpa, LLC; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. ; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Section 1.4 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.

- For more detailed information about our pharmacies, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.HSMedicareRx.com.

- **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, see Chapters 3 and 4 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **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. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.5 You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage

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 health care 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 that you can use to give your directions in advance in these situations 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 health care"** 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.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service for assistance in locating an advanced directive form.
- **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.

What if your instructions are not followed?

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 the appropriate state-specific agency, for example, your State Department of Health.

Section 1.6 You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan 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 members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

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:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- For information on the Quality Improvement Program for your specific health plan, call the Customer Service number on the back of your UnitedHealthcare member ID card. You may also access this information via the website (https://www.uhcmedicaresolutions.com/resources/ma-pdp-information-forms.html). Select, "Commitment to Quality."
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can **contact Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this **Evidence of Coverage** booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from your plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and pharmacist that you are enrolled in your plan.** Show your UnitedHealthcare member 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 health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - 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 health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Your prescription drug coverage is provided through contract with your employer group. Please contact the employer's benefits administrator for information about your plan premium, if applicable. If you have a plan premium, you must pay your plan premiums to continue being a member of our plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total

cost). Chapter 4 tells what you must pay for your Part D prescription drugs.

- If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan. Please Note: ERS pays this penalty once you are enrolled in the plan.
- 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 member of the plan.

- **Tell ERS if you move.** If you are going to move, it's important to tell ERS right away by calling toll-free at (877) 275-4377, (TTY users should call 711 or (800) 735-2989) 7 a.m. – 5:30 p.m. CT, Monday – Friday.
  - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area.
  - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

MAKING COMPLAINTS

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

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.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

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.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 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.

Get help from an independent government organization

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 our plan 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. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

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

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

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, **Section 4, "A guide to the basics of coverage decisions and appeals."**	**No.** My problem is <u>not</u> about benefits or coverage. Skip ahead to **Section 7** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service, or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: The big picture

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 have 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.

Section 4.2 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 us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can get free help from your State Health Insurance Assistance Program (see Section 2 of this chapter).

- **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 Customer Service (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 www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) 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. You must give our plan a copy of the signed form.
- **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.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (**A guide to the basics of coverage decisions and appeals**)? If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's **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 reference books. See Chapter 3, Section 3 for more information about a medically-accepted indication.)

- **This section is about your Part D drugs 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 Part D drugs, the List of Covered Drugs (Formulary), rules and restrictions on coverage, and cost information, see Chapter 3 (**Using the plan's coverage for your Part D prescription drugs**) and Chapter 4 (**What you pay for your Part D prescription drugs**).

Part D coverage decisions and appeals

As discussed in Section 4 of 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 Terms	An initial coverage decision about your Part D 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 plan's **List of Covered Drugs (Formulary)**
  - Asking us to waive a restriction on the plan's 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 plan's 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.) Start with **Section 5.2** of this chapter
If you want us to cover a drug on our 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. Skip ahead to **Section 5.4** of this chapter.
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.) Skip ahead to **Section 5.4** of this chapter.
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.) Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan 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 three 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 our plan's List of Covered Drugs (Formulary).** (We call it the "Drug List" for short.)

Legal Terms	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 drugs in Tier 3. You cannot ask for an exception to the copayment amount we require you to pay for the drug.

2. **Removing a restriction on the plan's coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on the plan's List of Covered Drugs (Formulary) (for more information, go to Chapter 3).

Legal Terms	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:
  - **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 our plan's Drug List is in one of 3 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 Terms	Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.

- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

- We do not lower the cost-sharing level for high cost specialty drugs.

Section 5.3 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, our Drug List includes more than 1 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 or are likely to cause an adverse reaction or other harm.

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. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

1 STEP 1: You ask our plan 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.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our plan 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. For the details, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are asking for a coverage decision about your Part D prescription drugs.** Or if you are asking us to pay you back for a drug, go to the section called, **Where to send a request asking us to pay for our share of the cost of a drug you have received.**

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug**, start by reading Chapter 5 of this booklet: **Asking us to pay our share of the costs for covered drugs.** Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our 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 mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

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

Legal Terms	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 ask for 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), our plan 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. For more information about the process for making complaints, see Section 7 of this chapter.)

2 Step 2: Our plan considers 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.

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 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**
  - 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 you can appeal.

Deadlines for a "standard" coverage decision about payment 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 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 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 you can appeal.

3 STEP 3: If we say no to your coverage request, you decide if you want to make an appeal.

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

Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

1 STEP 1: You contact our plan 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.**
  - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, **How to contact us when you are making an appeal about your Part D prescription drugs**.
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact us when you are making an appeal about your part D prescription drugs).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **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 Terms	A "fast appeal" is also called an **"expedited redetermination."**

- If you are appealing a decision our plan 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" in Section 5.4 of this chapter.

2 STEP 2: Our plan considers 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 for a drug you have not received yet. 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 you can appeal our decision.
- If you are requesting that we pay you back 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 give you a decision within 14 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 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 30 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 you can appeal our decision.

3 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).

Section 5.6 Step-by-step: 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 Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

1 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.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

2 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 our plan 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 our plan.
- 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 a "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 a "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 drug 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.

3 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 or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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 (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **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 or attorney adjudicator **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 or attorney adjudicator 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 or attorney adjudicator 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 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 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.

MAKING COMPLAINTS

SECTION 7 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. Go to Section 4 of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems **only**. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

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

Complaint	Example
Quality of your medical 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, poor customer service or other negative behaviors	Has someone been rude or disrespectful to you? Are you unhappy with how Customer Service has treated you? Do you feel you are being encouraged to leave the plan?
Waiting times	Have you been kept waiting too long by pharmacists? Or by Customer Service or other staff at our plan? Examples include waiting too long on the phone or when getting a prescription.

Complaint	Example
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 Sections 4-6 of 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, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When 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

Section 7.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms	What this section calls 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**."

Section 7.3 Step-by-step: Making a complaint

1 STEP 1: Contact us promptly — either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. **(866) 868-0609** (TTY: **711**), 7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT, Saturday.
- **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.
- We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

  If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address/fax numbers for filing complaints is located in Chapter 2 under "How to contact us when you are making a complaint about your Part D prescription drugs."
- **Whether you call or write, you should contact Customer Service 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 give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance**."

2 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.

Section 7.4 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.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (**without** making the complaint to our plan).
  - 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, Section 4, 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 our plan and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about HealthSelect Medicare Rx 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 the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Chapter 8

Ending your membership in the plan

Chapter 8

Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might decide to leave the plan.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 4 tells you about situations when we must end your membership.

If you are leaving your plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

In the event you choose to end your membership in our plan, re-enrollment may not be permitted, or you may have to wait until ERS' next Open Enrollment Period. You should consult with ERS regarding the availability of other coverage prior to ending your plan membership outside of ERS' Open Enrollment Period.

It is important to understand ERS's eligibility policies, and the possible impact to your retiree health care coverage options before submitting your request to end your membership in our plan.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. Please contact ERS for more information on ending your membership in our plan.

Section 2.1 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- Call ERS
- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You** 2021 Handbook.
  - Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 Until your membership ends, you must keep getting your drugs through our plan

Section 3.1 Until your membership ends, you are still a member of our plan

If you leave the HealthSelect Medicare Rx plan, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your prescription drugs through our plan.

- **You should continue to use network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail order pharmacy services.

SECTION 4 We must end your membership in the plan in certain situations

Section 4.1 When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- We are notified that you no longer meet the eligibility requirements of the plan.
- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service, which includes the 50 United States, the District of Columbia and the U.S. territories.
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's service area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave your plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your UnitedHealthcare member ID card to get prescription drugs. (We cannot make you leave our plan 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.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are printed on the back cover of this booklet).

Section 4.2 We cannot ask you to leave our plan for any reason related to your health

The HealthSelect Medicare Rx plan is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 4.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

Chapter 9

Legal notices

Chapter 9
Legal notices

SECTION 1 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.

SECTION 2 Notice about non-discrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **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 within the service area. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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 at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 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, our plan, 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 laws.

SECTION 4 Third party liability and subrogation

For purposes this Section Four only, when this Section Four says "we," "us," or "our," it means UnitedHealthcare for itself and, as the pharmacy benefit manager for HealthSelect Medicare Rx, on behalf of HealthSelect Medicare Rx and ERS.

In the case of injuries or illness caused by or alleged to have been caused by any act or omission of a third party, and any complications incident thereto, we shall cover all Part D covered drugs. However, you agree to promptly notify UnitedHealthcare of the injury or illness and agree to reimburse us or our designee for the cost of all such drugs provided immediately upon obtaining a monetary recovery, whether due to settlement or judgment, as a result of such injuries.

You agree to cooperate in protecting the interests of UnitedHealthcare or its designee under this provision. You shall not settle any claim, or release any person from liability, without the written consent of UnitedHealthcare, wherein such release or settlement will extinguish or act as a bar to our right of reimbursement. Should you settle your claim against a third party and compromise the reimbursement rights of UnitedHealthcare or its nominee without our written consent, or otherwise fail to cooperate in protecting the reimbursement rights of UnitedHealthcare or its nominee, we may initiate legal action against you. Attorney fees will be awarded to the prevailing party.

Benefits paid by us may also be considered to be benefits advanced.

The Plan has a right to subrogation and reimbursement. Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree to assign us all rights of recovery against such Third Parties; to the extent of the reasonable value of services and benefits we provide to you, plus reasonable costs of collection. We or any of our subsidiaries or owned affiliates are not a Third Party under this plan.

The following is agreed upon between you and us:

- You will cooperate with us in protecting our legal rights to subrogation and reimbursement; and you acknowledge that our rights under this Section will be considered as the first priority claim against any Third Parties, to be paid before any of your other claims are paid. Specifically, but without limitation, you agree to: (i) provide any relevant information we may request; (ii) sign and deliver such documents as we or our agents may reasonably request to secure the subrogation claim; (iii) respond to requests for information about any accidents or injuries; (iv) make court appearances; and (v) obtain the consent of the plan or our agents before releasing any party from liability for or payment of medical expenses. We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf and (vi) you may not accept any settlement that does not fully reimburse us without its written approval.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- You will do nothing to prejudice our rights under this provision, either before or after the need for drugs under this EOC. We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit on our own behalf as your subrogee. Your failure to cooperate in this manner shall be deemed a breach of this contract and may result in the institution of legal action against you.
- We will not use the rights enumerated throughout this Section to affect or impair any parental financial obligations, such as child support, associated with Pregnancy.
- No court costs or attorneys fees may be deducted from our recovery without our express written consent; and no so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right. We are not required to participate in or pay court costs or attorneys fees to any attorney or other representative or agent hired by you to pursue a claim relating to your Sickness or Injury.
- We may collect, at our opinion, amounts from proceeds of any Third Party settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether you or your legal representative have been made whole. You will hold any proceeds of such a Third Party settlement or judgment in a constructive trust for our benefit under these subrogation provisions. We will be entitled to recover from you reasonable attorney fees incurred in collecting proceeds held by you.
- The plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages.
- The plan’s rights to recovery will not be reduced due to your own negligence.
- We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer’s legal representative or other third party and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.

- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- We have the responsibility for administering the terms and conditions of the subrogation and reimbursement rights and have such powers and duties as are necessary to discharge these duties and functions, including the exercise of discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

SECTION 5 Member liability

In the event we fail to reimburse a network pharmacy's charges for covered drugs, or in the event that we fail to pay a non-network pharmacy for prior authorized covered drugs occurring when you were actively enrolled in the plan, you will not be liable for any sums owed by us.

We will pay for certain drugs dispensed by a non-network pharmacy under certain circumstances, subject to the limitations contained in Chapter 3.

If you enter into a private contract with a non-network provider, neither the plan nor Medicare will pay for those services.

SECTION 6 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or Federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your drugs exceeds such coverage. You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.

SECTION 7 Contracting network pharmacies

The relationships between us and our network pharmacy providers are independent contractor relationships. None of the network pharmacy providers or their pharmacists or employees are employees or agents of UnitedHealthcare Insurance Company. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare Insurance Company is an employee or agent of the network pharmacy.

SECTION 8 Disclosure

HealthSelect Medicare Rx is an Employer Prescription Drug Plan provided by ERS and administered by UnitedHealthcare Insurance Company, a Medicare-approved Part D sponsor. Enrollment in UnitedHealthcare depends on UnitedHealthcare's contract renewal with Medicare.

SECTION 9 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered drugs under this **Evidence of Coverage** and the Schedule of Benefits or be used in defense of a legal action unless it is contained in a written application.

SECTION 10 Information upon request

As a plan member, you have the right to request information on general coverage and comparative plan information.

SECTION 11 Commitment of Coverage Decisions

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage.

Clinical Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Chapter 10

Definitions of important words

Chapter 10
Definitions of important words

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare.

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. Chapter 7 explains appeals, including the process involved in making an appeal.

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. Chapter 2 explains how to contact CMS.

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, 5%).

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 member has to pay when drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires 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 copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 3 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 the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal

decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by your plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer) 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.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily cost-sharing rate – 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 copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Daily Cost Share applies only if the drug is in the form of a solid oral dose (e.g., tablet or capsule) when dispensed for less than a one-month supply under applicable law. The Daily Cost Share requirements do not apply to either of the following:

1. Solid oral doses of antibiotics.
2. Solid oral doses that are dispensed in their original container or are usually dispensed in their original packaging to assist patients with compliance.

Deductible – The amount you must pay for prescriptions before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. 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, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on your plan sponsor's drug list (a formulary exception), or get a non-preferred drug at a preferred lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits 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 our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $4,130.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan 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 health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

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, a Programs of All-inclusive Care for the Elderly (PACE) plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

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 Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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 (Member of your Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who participates in your plan and whose participation has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our 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 health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care 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 with our plan to coordinate or provide covered drugs to members of your plan. As explained in this **Evidence of Coverage**, most drugs you get from out-of-network pharmacies are not covered by your plan 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.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

Part C – see "Medicare Advantage (MA) Plan."

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.

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 after you are first eligible to join a Part D plan. 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 late enrollment penalty rules do not apply to you. If you receive "Extra Help," you do not pay a a penalty, even if you go without "creditable" prescription drug coverage. ERS pays once enrolled into the plan.

Plan Sponsor – Your former employer, ERS.

Plan Year – The period of time ERS has contracted with us to provide covered services to you through the plan. Your ERS' plan year is listed inside the front cover of the **Evidence of Coverage**.

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

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our drug list (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 health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Service Area – A geographic area 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.

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.

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.

UnitedHealthcare Customer Service:

Call **(866) 868-0609**
Calls to this number are free.
7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT, Saturday.
Customer Service also has free language interpreter services available for non-English speakers.

TTY: **711**
Calls to this number are free.
7 a.m. – 7 p.m. CT, Monday – Friday; 7 a.m. – 3 p.m. CT, Saturday.

Write: **P.O. Box 30769, Salt Lake City, UT 84130-0769**

www.HSMedicareRx.com

State Health Insurance Assistance Program
State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

You can call the SHIP in your state at the number listed in Chapter 2, Section 3.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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