Evidence of Coverage

January 1 – December 31, 2023

University of California
High Option Supplement to Medicare and Medicare PPO

Your Medicare Prescription Drug Coverage as a Member of Navitus MedicareRx Prescription Drug Plan (PDP)

This document gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

This plan, Navitus MedicareRx (PDP), offered by Dean Health Insurance, Inc., is a Federally-Qualified Medicare Contracting Prescription Drug Plan. (When this *Evidence of Coverage* says "we", "us", "plan", "our plan" or "our", it means Navitus MedicareRx.)

The University of California has implemented an Employer Group Waiver Plan (EGWP) for Medicare-eligible retirees. This plan is administered by Navitus Health Solutions. This means that Medicare-eligible retirees and/or dependents are enrolled in a Group Medicare Part D Plan. Your employer group plan also includes supplemental coverage that wraps around the benefits provided by Medicare Part D. For plan premium or enrollment questions, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific).

This document is available for free in Spanish. This document is also available in alternate formats (e.g., braille, large print, audio) as applicable.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2024.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan cost sharing;
- Your prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

NAVITUS
MedicareRx (PDP)

OMB Approval 0938-1051 (Expires: February 29, 2024) S9701_2023_UCA_EOC_V01_C

2023 Evidence of Coverage

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CHAPTER 1
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Navitus MedicareRx, which is a Medicare Prescription Drug Plan (PDP)

You are covered by Original Medicare and your UC Medicare PPO or UC High Option Supplement to Medicare plan for your health care coverage, and you get your Medicare prescription drug coverage through our plan, Navitus MedicareRx. However, cost sharing and provider access in this plan differ from Original Medicare.

Navitus MedicareRx 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. In addition, your retiree drug coverage includes non-Medicare supplemental drug coverage provided by your Navitus MedicareRx benefits.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of Navitus MedicareRx.

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 document.

If you are confused, concerned, or just have a question, please contact Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Navitus MedicareRx covers your care. Other parts of this contract include your enrollment form, 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 enrolled in Navitus MedicareRx between January 1, 2023, and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Navitus MedicareRx after December 31, 2023. We can also choose to stop offering the plan in your service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve Navitus MedicareRx each year. You can continue each year to get Medicare coverage as a member of our 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 our plan as long as:

- You have 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 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Section 2.2 Here is the plan service area for Navitus MedicareRx

Navitus MedicareRx is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described as all 50 states and Puerto Rico. The service area excludes most U.S. Territories, such as the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

If you plan to move out of the service area, you cannot remain a member of this plan. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location. If you plan to move out of the service area, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific).

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 2.3 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 Navitus MedicareRx if you are not eligible to remain a member on this basis. Navitus MedicareRx must disenroll you if you do not meet this requirement.

SECTION 3 Important Membership Materials You Will Receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership 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 plan membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card.

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

Section 3.2 Pharmacy Directory

The pharmacy directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 3, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

You can find pharmacy information on our website at https://memberportal.navitus.com. Also, there is a pharmacy search tool on the member portal, click on *Pharmacy Search* on the top navigation bar. You are able ask about network pharmacies by calling Navitus MedicareRx Customer Care. If you require the *Pharmacy Directory*, you can ask for a copy from Customer Care.

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

The plan has a *List of Covered Drugs (Formulary)*. It tells which Part D prescription drugs are covered under the Part D and/or supplemental benefits included in Navitus MedicareRx. 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 Navitus MedicareRx Formulary.

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

We will provide you a copy of the most up-to-date Formulary electronically. We may cover additional drugs that are not included in the Formulary. If one of your drugs is not listed in the Formulary, you should visit our website or contact Customer Care to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (https://memberportal.navitus.com) or call Customer Care.

SECTION 4 Your monthly costs for Navitus MedicareRx

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

In some situations, your plan premium 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 which help people with limited resources pay for their drugs. 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 have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert and "Extra Help" applies to you, please call Customer Care, and ask for the "LIS Rider". Please contact Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs". If you need a copy, you can download it 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/TDD users call 1-877-486-2048.

Section 4.1 Plan Premium

Your coverage with Navitus MedicareRx is provided through a contract with your former employer or union. **For information concerning the actual premiums you will pay, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific).**

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums, as applicable, to remain a member of the plan. This includes your premium for Part B. It *may* also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional amount that must be paid for Part D coverage 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.

The Part D late enrollment penalty is considered part of your plan premium. When you first enroll in Navitus MedicareRx, we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could be disenrolled from the plan.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or 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.
    - **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.

  - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not 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 2023, this average premium amount is $32.74. This amount may change for 2024.
- 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 $32.74, which equals $4.58. 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.
- **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.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. 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. However, 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.

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this

amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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. 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. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, 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/TDD 1-800-325-0778).

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

Please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific) to find out what your plan premium is and how to pay for it. Your benefits administrator can discuss different payment options with you, if applicable.

What to do if you are having trouble paying your plan premium

If you are having trouble paying your premium on time, please contact Customer Care to see if we can direct you to programs that will help with your plan premium.

If your membership is ended because you did not pay your group's premiums (if applicable), you will still have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium and/or your Part D late enrollment penalty, if owed (within our grace period), you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 7 of this document tells how to make a complaint or you can call us at 1-833-837-4309, 24 hours a day, 7 days a week

except on Thanksgiving and Christmas Day. TTY/TDD users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

Medicare Part D Coverage: No. Your plan is not allowed to change the amount charged for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year your plan will tell you later this year and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. 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. 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.

Supplemental Coverage: For questions regarding changes to your supplemental (wrap) coverage premium, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific). Remember: Your total group health insurance premium includes the cost of your prescription drug benefits, including this plan.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information 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.

Let us know about these changes:

- Changes to your name, your address, your phone number, or email address
- 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 Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. **Please remember to also notify the RASC so they will have your most up-to-date contact information on file.**

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.

SECTION 7 How other insurance works with our plan

Other insurance

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. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union 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/domestic partner 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.

CHAPTER 2
Important phone numbers and resources

SECTION 1 Navitus MedicareRx contacts (how to contact us, including how to reach Customer Care)

How to contact our plan's Customer Care

For assistance with claims, billing, or member card questions, please call or write to Navitus MedicareRx Customer Care. We will be happy to help you.

Method	Customer Care – Contact Information
CALL	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.
WRITE	Navitus MedicareRx (PDP) Customer Care P.O. Box 1039 Appleton, WI 54912-1039
WEBSITE	https://memberportal.navitus.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, coverage determinations, appeals, and/or complaints*)).

You may call us if you have questions about our coverage decision processes your request against both your Group Part D and Navitus MedicareRx coverage.

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Members can reach Navitus Customer Care 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.
FAX	1-855-668-8552
WRITE	Navitus MedicareRx (PDP) Prior Authorization P.O. Box 1039 Appleton, WI 54912-1039
WEBSITE	https://memberportal.navitus.com

How to contact us when you are making an appeal or complaint 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*)).

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. 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	Appeals or Complaints for Part D Prescription Drugs – Contact Information
CALL	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Customer Care also has free language interpreter services available for non-English speakers.
FAX	1-844-268-9791
WRITE	Navitus MedicareRx (PDP) Grievances & Appeals P.O. Box 1039 Appleton, WI 54912-1039
MEDICARE WEBSITE	You can submit a complaint about Navitus MedicareRx 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. If you have received a bill or paid for services (such as a pharmacy bill) that you think we should pay for, you may need to ask the plan for reimbursement to pay the pharmacy bill, 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	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Customer Care also has free language interpreter services available for non-English speakers.
FAX	1-855-668-8550
WRITE	Navitus MedicareRx (PDP) Manual Claims P.O. Box 1039 Appleton, WI 54912-1039
WEBSITE	https://memberportal.navitus.com

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/TDD	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 documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool: Provides** Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about Navitus MedicareRx: • **Tell Medicare about your complaint:** You can submit a complaint about Navitus MedicareRx 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 and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD 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. Please refer to **Exhibit A** for the name and contact information of the specific SHIP in your state.

SHIP is an independent (not connected with any insurance company or health plan) 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 understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. They can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on "**Talk to Someone**" in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Please refer to **Exhibit B** for the name and contact information of the specific Quality Improvement Organization in your area.

The QIO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. The QIO is an independent organization. It is not connected with our plan.

You should contact the QIO if you have a complaint about the quality of care you have received. For example, you can contact them if you were given the wrong medication or if you were given medications that interact in a negative way.

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. 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 8:00 am to 7:00 pm, 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/TDD	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 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov/

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs":

- **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+).)
- **Qualifying 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, please refer to **Exhibit C** for the name and contact information of your state specific Medicaid program.

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/6-ways-to-get-help-with-prescription-costs) provides

information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

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 (if applicable), and prescription copayments and/or coinsurance. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify 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/TDD 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 8 am to 7 pm, Monday through Friday. TTY/TDD 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, our plan has a process for 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.

- If you do not have evidence of "Extra Help", notify the pharmacy when you pick up your prescription. The pharmacy will contact us, and we will work with Medicare to get this evidence for you.
- 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. We will forward a check to you in the amount of your overpayment. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, you 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 Care if you have questions.

There are programs in Puerto Rico 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/TDD 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)?

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs.

To find out more about a State Pharmaceutical Assistance Program (SPAP), please refer to **Exhibit D** for the name and contact information of your state specific SPAP.

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 on the ADAP formulary 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.

For information on eligibility criteria, covered drugs, or how to enroll in the program, refer to **Exhibit E** for the name and contact information of your state specific ADAP.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs (SPAP) 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.

To find out more about a State Pharmaceutical Assistance Program (SPAP), please refer to **Exhibit D** for the name and contact information of your state specific SPAP.

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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm 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/TDD	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 "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 as part of this plan, you may call the RASC or Customer Care if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. Please contact Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. You may also call 1-800-MEDICARE (1-800-633-4227; TTY/TDD number is 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**. That benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

Using the plan for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D 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 2023* handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.1 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 you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy, or through the plan's mail-order and specialty pharmacy service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)*. (See Section 3, *Your drugs need to be on the plan's "Formulary"*.)
- 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 and specialty pharmacy service

Section 2.1 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 on the plan's Formulary.

Section 2.2 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 https://memberportal.navitus.com, and/or call Navitus MedicareRx Customer Care.

You may go to any of our network pharmacies. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

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 pharmacy in your area, you can get help from Customer Care or use the *Pharmacy Directory*. You can also find information on our website at https://memberportal.navitus.com. There is a pharmacy search tool on the member portal, click on *Pharmacy Search* on the top navigation bar.

What if you need a specialized pharmacy?

Some 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 LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Care.
- 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, pharmacy coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory*, call Customer Care or use the *Pharmacy Search* tool at the top navigation bar on the member portal.

Section 2.3 Using the plan's mail-order service

Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order **up to a 90-day supply**. (Specialty drugs are only available for up to a 30-day supply.)

To get order forms and information about filling your prescriptions by mail call Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

You may use any contracted pharmacy you like, currently the recommended mail order pharmacy is **Costco Mail Order Pharmacy**. **Note:** Costco Mail Order is not to be confused with Costco Warehouse/Club Stores. You do not need to be a member of Costco Warehouse/Club Stores to utilize Costco Mail Order Pharmacy services.

Costco Mail Order can be reached at 1-800-607-6861. Costco representatives are available Monday through Friday, 7am to 9pm CST and Saturdays 11:30am to 4pm CST. Refill orders can be placed and tracked 24 hours a day, 7 days a week. Your physician can send new prescriptions in by calling (1-800-607-6861) or by fax at 1-888-545-4615.Usually a mail-order pharmacy order will get to you in no more than 14 days.

> **New prescriptions the pharmacy receives directly from your doctor's office**.
> After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop 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.
>
> **Refills on mail-order prescriptions.** For refills, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

What should I do if I need my mail order prescription urgently from Costco?

Usually Costco Mail Order prescriptions will get to you within 14 days. If the medication does not arrive in that timeframe, you should contact Costco to report that you did not receive your prescription. Costco will verify how many days of medication you have left.

If you have 5 days or less of medication left, you should contact your doctor to ask for a two-week supply to be called into your local pharmacy.

If you have more than 6 days remaining, Costco will continue to process your order. Costco can expedite shipping your order at an additional cost to you. The overnight shipping happens after the usual processing time of 24 to 96 hours.

In an emergency circumstance where Costco failed to comply with their protocol, they will expedite the patient medication at Costco's cost. If Costco provided unrealistic expectations to you which results in you not getting your medication in time, Costco will investigate and immediately resolve the situation to prevent gaps in therapy.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Communication preferences can be updated by contacting our recommended mail order partner, **Costco Mail Order Pharmacy.**

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 our plan's Formulary. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you get a long-term supply of maintenance drugs. Other retail pharmacies may not agree to offer a long-term supply. In this case you may be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply. You can also call Customer Care for more information at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

You may be able to receive greater than a 1-month supply for most of the drugs on your Formulary. Drugs noted with "**NDS**" (**N**on-extended **D**ay **S**upply) on the list are limited to a 1-month supply for retail, mail-order and specialty pharmacies.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. **Please check first with Customer Care** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to get a covered drug in a timely manner within your area because there are no network pharmacies within a reasonable driving distance that provides 24-hour services.
- If you are trying to fill a covered drug that is not regularly stocked at an eligible network retail pharmacy. (These drugs include orphan drugs or other specialty pharmaceuticals.)
- Please note that out-of-network prescriptions are limited to reimbursement for a single refill of up to a 30-day supply. If you are planning an extended stay in an area without a network pharmacy, please call Customer Care for assistance in signing up for mail order service.
- If you are filling prescriptions at an out-of-network pharmacy related to a medical emergency.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2 explains how to ask the plan to pay you back.)

After all benefits are provided under your retiree drug coverage when using out-of-network pharmacies, in addition to paying your copayments/coinsurances you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

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

Section 3.1 The "Formulary" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary)*".

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Formulary are only those covered under Medicare Part D and/or your plan.

We will generally cover a drug on the plan's Formulary 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 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 Formulary includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Formulary, when we refer to "drugs", this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products.

What is *not* on the Formulary?

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 about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Formulary. In some cases, you may be able to obtain a drug that is not on the Formulary. For more information, please see Chapter 7.

Section 3.2 There are four "cost-sharing tiers" for drugs on the Formulary

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

- **Tier $0**: Select generics (not all dosages of these drugs are covered at the Select Generics cost share)
- **Tier 1**: Preferred generics and certain lower cost brand products
- **Tier 2**: Preferred brand products and some higher cost non-preferred generics
- **Tier 3**: Non-preferred products (could include some higher cost non-preferred generics)
- **Tier 4**: Specialty products

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

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 Formulary?

You have four ways to find out:

1. Check the most recent Formulary we provided electronically. If one of your drugs is not listed in the Formulary, you should visit our website or contact Customer Care to find out if we cover it.
2. Visit the plan's website (https://memberportal.navitus.com). On the top navigation bar of the member portal, click on My Plan, then Forms and Documents to find the Formulary. The Formulary on the member portal is always the most current.
3. On the member portal, you can look up drug information which includes cost-sharing information, clinically appropriate formulary alternatives, when available, and the drug list status of each drug, including any requirements applicable to each alternative drug.
4. Call Customer Care to find out if a particular drug is on the plan's Formulary or to ask for a copy of the list.

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 encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Formulary.

Please note that sometimes a drug may appear more than once in our formulary. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your prescriber will have to take extra steps in order for us to cover the drug. Contact Customer Care to learn what you

or your prescriber 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)

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.**

The Formulary indicates what you will pay for your drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. When a generic drug is available and you or your prescriber choose the brand-name drug, you must pay the applicable brand copay plus the difference between the cost of the brand-name drug and the generic equivalent (referred to as Dispense as Written (DAW) penalty). With a prior authorization request, an exception for medical necessity may be made and you will pay the Tier 3 (non-preferred) applicable copay.

Note: The difference between the cost of the brand drug and the generic (DAW penalty) does not accumulate toward the *UC High Option Supplement to Medicare* Annual Prescription Maximum Out-of-Pocket.

This Dispense as Written (DAW) cost-sharing penalty will not exceed the cost of the medication.

Coverage for out-of-country drugs

Outpatient prescription drugs are not covered by Medicare Part D plans when they are filled by pharmacies outside of the United States.

Your UC plan provides coverage for outpatient prescription drugs when all of the following apply:

- You remain a permanent resident of the United States while you are out of country,
- The drug is approved by the Food and Drug Administration (FDA), *and*
- The drug would be a covered drug by your plan if the drug was filled by a pharmacy located within the United States.

When you receive coverage for outpatient prescription drugs filled at a pharmacy outside the United States, you will need to pay the full cost of the drug and request that we reimburse you for our share. Your share of a covered outpatient drug will be your coinsurance or copayment amount. Please see "How to ask us to pay you back" in Chapter 5, Section 2, for detailed instructions.

Getting plan approval in advance

For certain drugs, you or your prescriber need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**". This is put in place to ensure medication safety and help 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 usually 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 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 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

There are situations where there is a prescription drug you are taking, or one that you and your prescriber think you should be taking that is not on our 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.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the Formulary 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. Drugs of our Tier 4 (Specialty drugs) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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

If your drug is not on the Formulary or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- 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 must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your prescriber about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Formulary** OR **is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan**.**
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (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 facility and need a supply right away:**

  We will cover one 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.

Level of Care Changes

We will provide a one-time 31-day transition supply per drug, which will cover a temporary supply if you have a change in your medications due to a level-of-care change. A level of care change may include:

- Entering or leaving a LTC facility
- Being discharged from a hospital to a home
- Ending a Medicare Part A skilled nursing facility stay
- Giving up hospice status and reverting back to standard Medicare benefits

- Ending an LTC facility stay and returning home

For questions about a temporary supply, call Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

During the time when you are using a temporary supply of a drug, you should talk with your prescriber to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your prescriber about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your prescriber find a covered drug that might work for you.

2) You can ask for an exception

You and your prescriber can ask the plan to make an exception and cover the drug in the way you would like it covered. If your prescriber says that you have medical reasons that justify asking us for an exception, your prescriber can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Formulary. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year, and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your prescriber want to ask for an exception, Chapter 7, Section 5.4 tells you 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, talk to your prescriber. There may be a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your prescriber find a covered drug that might work for you.

You can ask for an exception

You and your prescriber 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 prescriber says that you have medical reasons that justify asking us for an exception, your prescriber can help you request an exception to the rule.

If you and your prescriber 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.

Drugs of our Tier 4 (specialty drugs) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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

Section 6.1 The Formulary can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Formulary. For example, the plan might:

- **Add or remove drugs from the Formulary**.
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic drug.**

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

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

Information on changes to drug coverage

When changes to the Formulary occur, we update our online Formulary on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes were made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

Advance General Notice that Navitus MedicareRx may immediately substitute new generic drugs: In order to immediately replace brand name drugs with new therapeutically equivalent generic drugs (or change the tiering or the restrictions, or both, applied to a brand name drug

after adding a new generic drug), plan sponsors that otherwise meet the requirements must provide the following advance general notice of changes:

- **A new generic drug replaces a brand name drug on the Formulary (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 Formulary if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Formulary, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. 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). 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.
  - 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.
- **Unsafe drugs and other drugs on the Formulary that are withdrawn from the market**
  - Sometimes a drug may be considered unsafe or taken off the market for another reason. If this happens, we will immediately remove the drug from the Formulary. 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 Formulary**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Formulary or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - For these changes, 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 work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.

- 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.

Changes to the Formulary that do not affect you during this plan year

We may make certain changes to the Formulary that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Formulary.

If any of these changes happen for a drug you are taking (except for 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 restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Formulary for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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 (except for certain excluded drugs covered under our supplemental drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we may pay for or cover it. (For information about appealing a decision, go to Chapter 7.)

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 or Puerto Rico.
- 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.
- 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.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans (Our plan covers some drugs ("Extra Covered Drugs") listed below through our supplemental drug coverage.) More information is provided below:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs 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

We offer additional coverage of some prescription drugs (supplemental drug coverage or "Extra Covered Drugs") not normally covered in a Medicare prescription drug plan. The amount you pay for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this document.)

In addition, if you are **receiving "Extra Help"** from Medicare to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. Please refer to the plan's Formulary or call Customer Care for more information. Please contact Customer Care at 1-833-837-4309. (TTY/TDD users should call 711) with questions. Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. However, if you have drug coverage through Medicaid, 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 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership ID card, at the network pharmacy you choose. 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 membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call Navitus MedicareRx Customer Care to get the necessary information by calling 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

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 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 your medical plan?

If you are admitted to a skilled nursing facility for a stay covered by Original Medicare, we will generally cover the cost of your prescription drugs during your stay. Once you leave the skilled nursing facility (or a hospital), the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

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 uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses, is part of our network. There is also a pharmacy search tool on our Member Portal at https://memberportal.navitus.com. If it isn't, or if you need more information or assistance,

please contact Customer Care. 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.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Formulary or is restricted in some way?

Please refer to Section 5.2 of this chapter about a temporary or emergency supply.

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

Your enrollment in Navitus MedicareRx doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, 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 Navitus MedicareRx in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or prescriber will determine whether to bill Medicare Part B or Navitus MedicareRx 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 retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, 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 have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable".

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 this notice 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 from your employer or retiree group plan to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or your former employer or union.

Section 9.6 What if you are in Medicare-certified Hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are 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 these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

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.

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 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 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 prescriber to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, 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 plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will 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 have 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 appeal. If you 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 for review and resolution. See Chapter 7 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, 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) to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs or are in a Drug Management Program (DMP) to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, 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, which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a personal medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your recommended to-do list 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 up to date and 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 this program, please contact Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

If you have specific questions about this program, please contact the Medication Therapy Management (MTM) program team. You can call us at 1-833-837-4304, Monday through Thursday 9 am to 6 pm Central Standard Time and on Friday 9 am to 4pm Central Standard Time. TTY/TDD users should call 711.

CHAPTER 4
What you pay for your Part D prescription drugs

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 provide 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 and "Extra Help" applies to you, please call Customer Care, and ask for the "LIS Rider".

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 Part D prescription drugs. 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. Some excluded drugs may be covered by our plan because of your supplemental (wrap) drug coverage.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3, Sections 1 through 4 explain these rules.

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

There are different types of out-of-pocket costs for Part D drugs. 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"**, if applicable, is the amount you pay for drugs before our plan begins to pay its share.
- **"Copayment"** is a fixed amount each time you fill a prescription.
- **"Coinsurance"** is a percentage of the total cost of the drug each time you fill a prescription.

Maximum out-of-pocket costs for prescription drugs

Once the maximum out-of-pocket is reached, you pay $0 for prescription drugs and Part D diabetic supplies for the remainder of the plan year.

Note: Medicare Part B diabetic supplies need to be paid by your Part B plan as primary. After which they can be put through Navitus MedicareRx benefits to pay secondary for those Part B supplies.

Prescription Maximum Out-of-Pocket (Supplement to Medicare)	
UC Medicare PPO with Rx Plan	Not Applicable
UC High Option Supplement to Medicare Plan	$1000 *
* Once you reach the $1,000 UC High Option Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year. (If the UC Maximum Out-Of-Pocket has not been met, the payment responsibility changes after Part D (PDP) TrOOP of $7,400 is met.)	

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

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

Your out-of-pocket costs 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 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage (if applicable)
  - The Initial Coverage 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 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 $7,400 in out-of-pocket costs within the calendar year, you will move on to the Catastrophic Coverage Stage.

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

Your out-of-pocket costs **do not include** any of these types of payments:

- Any monthly premiums.
- 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.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but 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 the 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 by calling Customer Care.

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

- We will help you. The Part D EOB report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $7,400, this report will tell you that you have moved on to the Catastrophic Coverage Stage.
- 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 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 Navitus MedicareRx members?

There are four "drug payment stages" for your prescription drug coverage under Navitus MedicareRx. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage. Details of each stage are in Sections 4 through 7 of this chapter.

The stages are:

- **Stage 1:** Yearly Deductible Stage (if applicable)
- **Stage 2:** Initial Coverage Stage
- **Stage 3:** Coverage Gap Stage
- **Stage 4:** Catastrophic Coverage Stage

Important Message About What You Pay for Insulin – You won't pay more than $30 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier its's on.

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 summary 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:

- How much you have paid. This is called your "**out-of-pocket**" cost.
- 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.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D Explanation of Benefits* ("Part D EOB"). The Part D EOB includes:

- **Information for the 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 the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available 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 membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, 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, give us copies of these receipts. Here are examples of when you should give us copies of your drug receipts:
    - 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.
    - 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 1.
- **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. 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. 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 EOB", look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call Customer Care at 1-833-837-4309. (TTY/TDD users should call 711. Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.SECTION 4 There is no deductible for Navitus MedicareRx

There is no deductible for Navitus MedicareRx. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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 copayment and/or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has four cost-sharing tiers

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

- **Tier $0** includes select generics
- **Tier 1** includes preferred generics and certain lower cost brand products
- **Tier 2** includes preferred brand products and some higher cost non-preferred generics
- **Tier 3** includes non-preferred products (could include some higher cost non-preferred generics)
- **Tier 4** includes specialty products

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

Your pharmacy choices

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

- A network retail pharmacy.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order or specialty pharmacy.

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

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment and/or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on which tier. Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Cost-Sharing	**Retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing (in network)** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** Coverage is limited to certain situations; Chapter 3 has details. (up to a 30-day supply)
Tier $0 (Select generics; diabetic supplies after Part B pays primary)	$0 copayment	$0 copayment	$0 copayment	$0 copayment

Cost-Sharing	**Retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing (in network)** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** Coverage is limited to certain situations; Chapter 3 has details. (up to a 30-day supply)
Tier 1 (Preferred generics and certain lower cost brand products; insulin & Part D diabetic supplies)	$10 copayment	$10 copayment	$10 copayment	$10 copayment
Tier 2 (Preferred brand products and some higher cost non-preferred generics; insulin & Part D diabetic supplies)	$30 copayment	$30 copayment	$30 copayment	$30 copayment
Tier 3 (Non-preferred products (could include some higher cost non-preferred generics); insulin & Part D diabetic supplies)	$45 copayment	$45 copayment	$45 copayment	$45 copayment
Tier 4 (Specialty products)	$30 copayment	$30 copayment	$30 copayment	$30 copayment

Your drug copay or coinsurance may be less, based upon the cost of the drug and the coverage stage you are in.
The Formulary indicates what you will pay for your drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. When a generic drug is available and you or your prescriber choose the brand-name drug, you must pay the applicable brand copay *plus* the difference between the cost of the brand-name drug and the generic equivalent (referred to as Dispense as Written (DAW) penalty). With a prior authorization request, an exception for medical necessity may be made and you will pay the Tier 3 (non-preferred) applicable copay.

Note: The difference between the cost of the brand drug and the generic (DAW penalty) does not accumulate toward the *UC High Option Supplement to Medicare* Annual Prescription Maximum Out-of-Pocket.

This Dispense as Written (DAW) cost-sharing penalty will not exceed the cost of the medication.

Maximum Out-of-Pocket

Prescription Maximum Out-of-Pocket (Supplement to Medicare)	
UC Medicare PPO with Rx Plan	Not Applicable
UC High Option Supplement to Medicare Plan	$1000 *
* Once you reach the $1000 UC High Option Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year. **(If the UC Maximum Out-of-Pocket has not been met, the payment responsibility changes after Part D (PDP) TrOOP of $7,400 is met.)**	

For UC High Option Supplement to Medicare – once members reach the $1000 UC Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year.

- Out-of-pocket costs for Extra Covered Drugs apply toward the $1,000 out-of-pocket maximum, but not the Medicare TrOOP of $7,400.
- Members qualifying for the Coverage Gap Discount could reach Medicare TrOOP before the $1,000 out-of-pocket maximum because out-of-pocket expenses covered by the Coverage Gap Discount apply only toward the Medicare TrOOP, but not the UC out-of-pocket maximum. If this happens, members will continue to pay a copayment for Extra Covered Drugs until reaching the $1,000 out-of-pocket maximum. After that, the plan will pay 100% for all covered drugs (including Extra Covered Drugs).

For PPO Plan Members – members continue to pay the cost of Extra Covered Drugs, even after the CMS TrOOP is met.

Extra Covered Drug Benefits (Non-Medicare Part D) – Prescription Required

Formulary Cost Sharing	**Select Retail** (up to 90 days)
Part B Diabetic Supplies (Navitus MedicareRx will coordinate benefits, if submitted after Medicare Part B pays primary, including lancets, blood sugar diagnostics, calibration solutions and glucometers.)	$0 copay

Certain drugs that are excluded by law from coverage by Medicare Part D, may be included in the supplemental coverage of your drug plan. Drugs covered under the "Extra Covered Drugs" benefit, will be listed in the Formulary.

Extra Covered Drugs Cost Sharing	**Retail & Mail Order** (up to 30 days)	**Retail** (31-60 days)	**Retail** (61-90 days)	**Mail Order** (31-90 days)
Tier 1 non-Medicare covered drugs	$10 copay	$20 copay	$30 copay	$20 copay
Tier 2 non-Medicare covered drugs	$30 copay	$60 copay	$90 copay	$60 copay
Tier 3 non-Medicare covered drugs	$45 copay	$90 copay	$135 copay	$90 copay

Note: These Extra Covered Drugs do not count towards the Medicare TrOOP ($7,400) expenses and they do not qualify for lower catastrophic copays.

Member cost share per tier values in the above table, for:

- Cough and Cold Prescriptions
- Erectile Disfunction (ED) – with quantity limit (QL)
- Vitamins and Minerals Prescriptions

Coverage for Out of Country Drugs: Outpatient prescription drugs are not covered by Medicare Part D plans when they are filled by pharmacies outside of the United States. Your UC plan provides coverage for outpatient prescription drugs when all of the following apply:

- ✓ You remain a permanent resident of the United States while you are out of country, *and*
- ✓ The drug is approved by the Food and Drug Administration (FDA), *and*
- ✓ The drug would be a covered drug by your plan if the drug was filled by a pharmacy located within the United States.

When you receive coverage for outpatient prescription drugs filled at a pharmacy outside the United States, you will need to pay the full cost of the drug and request that we reimburse you for our share. Your share of a covered outpatient drug will be your coinsurance or copayment amount. Please see "How to ask us to pay you back" for detailed instructions, which can be found in the Evidence of Coverage, Chapter 5, Section 2.

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. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you may not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.
- Extended supplies (greater than a 1-month supply) may not be available for all medications. To verify if one of your medications is excluded from extended supplies, check the Formulary. Medications which do not qualify for extended supplies will be marked with **NDS** (**N**on-extended **D**ay **S**upply).

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Cost Sharing	**Retail cost sharing (in-network)** (31-60 day supply)	**Retail cost sharing (in-network)** (61-90 day supply)	**Mail-order cost sharing (in-network)** (61-90 day supply)
Tier $0 (Select generics; diabetic supplies after Part B pays primary)	$0 copayment	$0 copayment	$0 copayment
Tier 1 (Preferred generics and certain lower cost brand products; insulin & Part D diabetic supplies)	$20 copayment	$30 copayment	$20 copayment
Tier 2 (Preferred brand products and some higher cost non-preferred generics; insulin & Part D diabetic supplies)	$60 copayment	$90 copayment	$60 copayment
Tier 3 (Non-preferred products (could include some higher cost non-preferred generics; insulin & Part D diabetic supplies)	$90 copayment	$135 copayment	$90 copayment
Tier 4 (Specialty products)	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4
Extended supplies (greater than a 1-month supply) may not be available for all medications. To verify if your medication is excluded from extended supplies, check the Formulary. Medications which do **not** qualify for extended supplies will be marked with **NDS** (**N**on-extended **D**ay **S**upply) on the formulary.			

The Formulary indicates what you will pay for your drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. When a generic drug is available and you or your prescriber choose the brand-name drug, you must pay the applicable brand copay *plus* the difference between the cost of the brand-name drug and the generic equivalent (referred to as the **D**ispense **A**s **W**ritten (**DAW**) penalty). With a prior authorization request, an exception for medical necessity may be made and you will pay the Tier 3 (non-preferred) applicable copay.

Note: The difference between the cost of the brand drug and the generic (DAW penalty) does not accumulate toward the *UC High Option Supplement to Medicare* Annual Prescription Maximum Out-of-Pocket.

This Dispense as Written (DAW) cost-sharing penalty will not exceed the cost of the medication.

Maximum Out-of-Pocket

Prescription Maximum Out-of-Pocket (Supplement to Medicare)	
UC Medicare PPO with Rx Plan	Not Applicable
UC High Option Supplement to Medicare Plan	$1000 *
* Once you reach the $1000 UC High Option Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year. (If the UC Maximum Out-of-Pocket has not been met, the payment responsibility changes after Part D (PDP) TrOOP of $7,400 is met.)	

"Select Retail" Pharmacies

Select Retail pharmacies includes the following retail pharmacies: UC Medical Center retail pharmacies, Costco, CVS, Vons/Safeway, Walmart, and Walgreens.

Select Retail Pharmacy Cost Sharing	**Select Retail** (up to 90 days)
Tier 1 Drugs from Select Retail Pharmacies	$20 copay
Tier 2 Drugs from Select Retail Pharmacies	$60 copay
Tier 3 Drugs from Select Retail Pharmacies	$90 copay

Extra Covered Drug Benefits (Non-Medicare Part D) – Prescription Required

Formulary Cost Sharing	**Select Retail** (up to 90 days)
Part B Diabetic Supplies (Navitus MedicareRx will coordinate benefits, **if submitted after Medicare Part B pays primary**, including lancets, blood sugar diagnostics, calibration solutions and glucometers)	$0 copay

Certain drugs that are excluded by law from coverage by Medicare Part D, may be included in the supplemental coverage of your drug plan. Drugs covered under the "Extra Covered Drugs" benefit, will be listed in the Formulary.

Extra Covered Drugs Cost Sharing	**Retail & Mail Order** (up to 30 days)	**Retail** (31-60 days)	**Retail** (61-90 days)	**Mail Order** (31-90 days)
Tier 1 non-Medicare covered drugs	$10 copay	$20 copay	$30 copay	$20 copay
Tier 2 non-Medicare covered drugs	$30 copay	$60 copay	$90 copay	$60 copay
Tier 3 non-Medicare covered drugs	$45 copay	$90 copay	$135 copay	$90 copay

Note: These Extra Covered Drugs do not count towards the Medicare TrOOP ($7,400) expenses and they do not qualify for lower catastrophic copays.

Member cost share per tier values in the above table, for:

- Cough and Cold Prescriptions
- Erectile Disfunction (ED) – with quantity limit (QL)
- Vitamins and Minerals Prescriptions

Coverage for Out of Country Drugs: Outpatient prescription drugs are not covered by Medicare Part D plans when they are filled by pharmacies outside of the United States. Your UC plan provides coverage for outpatient prescription drugs when all of the following apply:

- ✓ You remain a permanent resident of the United States while you are out of country, *and*
- ✓ The drug is approved by the Food and Drug Administration (FDA), *and*
- ✓ The drug would be a covered drug by your plan if the drug were filled by a pharmacy located within the United States.

When you receive coverage for outpatient prescription drugs filled at a pharmacy outside the United States, you will need to pay the full cost of the drug and request that we reimburse you for our share. Your share of a covered outpatient drug will be your coinsurance or copayment amount. Please see "How to ask us to pay you back" for detailed instructions, which can be found in the Evidence of Coverage, Chapter 5, Section 2.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,660

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$4,660 limit for the Initial Coverage Stage**

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count toward your initial coverage limit.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the $4,660 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. **Your plan will continue to pay for your drug costs at the Initial Coverage Stage copayments when the Medicare plan does not; you will be responsible for your formulary copayment as applicable.**

For brand name drugs, both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive coverage for generic drugs. Only the amount you pay counts and moves you through the coverage gap.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $7,400, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

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

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

Cost-Sharing	**Retail cost sharing** (up to a 30-day supply)	**Retail cost sharing (in-network)** (31-90 day supply)	**Mail-order cost sharing (in network)** (up to a 90-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)
Tier $0 (Select generics; diabetic supplies after Part B pays primary)	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 1 (Preferred generics and certain lower cost brand products; insulin & Part D diabetic supplies)	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Preferred brand products and some higher cost non-preferred generics; insulin & Part D diabetic supplies)	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 3 (Non-preferred products (could include some higher cost non-preferred generics); insulin & Part D diabetic supplies)	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 4 (Specialty products)	$0 copayment	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4	$0 copayment

The Formulary indicates what you will pay for your drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. When a generic drug is available and you or your prescriber choose the brand-name drug, you must pay the applicable brand copay *plus* the difference between the cost of the brand-name drug and the generic equivalent (referred to as **D**ispense **A**s **W**ritten (DAW) penalty). With a prior authorization request, an exception for medical necessity may be made and you will pay the Tier 3 (non-preferred) applicable copay.

Note: The difference between the cost of the brand drug and the generic (DAW penalty) does not accumulate toward the *UC High Option Supplement to Medicare* Annual Prescription Maximum Out-of-Pocket.

This Dispense as Written (DAW) cost-sharing penalty will not exceed the cost of the medication.

Maximum Out-of-Pocket

Prescription Maximum Out-of-Pocket (Supplement to Medicare)	
UC Medicare PPO with Rx Plan	Not Applicable
UC High Option Supplement to Medicare Plan	$1000 *
* Once you reach the $1000 UC High Option Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year. **(If the UC Maximum Out-of-Pocket has not been met, the payment responsibility changes after Part D (PDP) TrOOP of $7,400 is met.)**	

For UC High Option Supplement to Medicare – once members reach the $1000 UC Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year.

- Out-of-pocket costs for Extra Covered Drugs apply toward the $1,000 out-of-pocket maximum, but not the Medicare TrOOP of $7,400.
- Members qualifying for the Coverage Gap Discount could reach Medicare TrOOP before the $1,000 out-of-pocket maximum because out-of-pocket expenses covered by the Coverage Gap Discount apply only toward the Medicare TrOOP, but not the UC out-of-pocket maximum. If this happens, members will continue to pay a copayment for Extra Covered Drugs until reaching the $1,000 out-of-pocket maximum. After that, the plan will pay 100% for all covered drugs (including Extra Covered Drugs).

For PPO Plan Members – members continue to pay the cost of Extra Covered Drugs, even after the CMS TrOOP is met.

Extra Covered Drug Benefits (Non-Medicare Part D) – Prescription Required

Certain drugs that are excluded by law from coverage by Medicare Part D, may be included in the supplemental coverage of your drug plan. Drugs covered under the "Extra Covered Drugs" benefit, will be listed in the Formulary.

Extra Covered Drugs Cost Sharing	**Retail & Mail Order** (up to 30 days)	**Retail** (31-60 days)	**Retail** (61-90 days)	**Mail Order** (31-90 days)
Tier 1 non-Medicare covered drugs	$10 copay	$20 copay	$30 copay	$20 copay
Tier 2 non-Medicare covered drugs	$30 copay	$60 copay	$90 copay	$60 copay
Tier 3 non-Medicare covered drugs	$45 copay	$90 copay	$135 copay	$90 copay

Note: These Extra Covered Drugs do not count towards the Medicare TrOOP ($7,400) expenses and they do not qualify for lower catastrophic copays.

Member cost share per tier values in the above table, for:

- Cough and Cold Prescriptions
- Erectile Disfunction (ED) – with quantity limit (QL)
- Vitamins and Minerals Prescriptions

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **The type of vaccine** (what you are being vaccinated for).

- Some vaccines are considered medical benefits. They are covered under Original Medicare or Medicare Part B.
- Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*

2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist may give the vaccine in the pharmacy or another provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Part D Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)

- You will pay the pharmacy your coinsurance/copayment for the vaccine itself which includes 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 (refer to your Anthem medical benefits).

- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5.
- You will be reimbursed the amount you paid less your normal coinsurance/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 itself 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 your coinsurance/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.
- 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.)

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

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 or you may receive a bill from a pharmacy. In these cases, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). Please note that depending on the coverage rules for your specific drug, there may be a difference in the amount you are reimbursed and the total amount. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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).

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

If you go to an out-of-network pharmacy, 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. Remember that we only cover out of network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion of these circumstances.

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 look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask 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 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. (This 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.

Please call Customer Care for additional information about how to ask us to pay you back and deadlines for making your request. Please contact Customer Care at 1-833-837-4309, (TTY/TDD users should call 711), with questions. Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

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 document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to us within 36 months** of the date you received the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster.
- Call Customer Care and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Navitus MedicareRx
Manual Claims
P.O. Box 1039
Appleton, WI 54912-1039

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, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. 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. We will send you a letter explaining the reasons why we are not sending the payment 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 the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY/TDD (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. This document is available for free in Spanish. 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 Care.

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 Navitus MedicareRx Customer Care by calling 1-833-837-4309. (TTY/TDD users should call 711). Available hours are 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. 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 at 1-800-368-1019 or TTY/TDD 1-800-537-7697.

<u>Spanish members:</u>

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se proporcionen de manera culturalmente competente y sean accesibles para todos los afiliados, incluidos aquellos con competencia limitada en inglés, habilidades de lectura limitadas, incapacidad auditiva o aquellos con diversos orígenes culturales y étnicos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, teletipos o conexión TTY/TDD (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios gratuitos de interpretación disponibles para responder preguntas de miembros que no hablan inglés. Este documento está disponible de forma gratuita en español. También podemos brindarle información en braille, en letra grande u otros formatos alternativos sin costo si la necesita. Estamos obligados a brindarle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información de nosotros de una manera que le resulte conveniente, llame a Atención al Cliente.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, llame al 1-833-837-4309 para presentar una queja formal ante Navitus MedicareRx (los usuarios de TTY/TDD deben llamar al 711). Estamos disponibles las 24 horas del día, los 7 días de la semana, excepto el Día de Acción de Gracias y Navidad. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente a la Oficina de Derechos Civiles al 1-800-368-1019 o TTY/TDD 1-800-537-7697.

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

You have the right to get your prescriptions filled or refilled at any of 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 of this document 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.
- You have rights related to your 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.
- Except for the circumstances noted below, if we intend to 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 or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - 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; typically, this requires that information that uniquely identifies you not be shared.

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 healthcare provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

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

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.

As a member of Navitus MedicareRx, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Care:

- **Information about our plan.** This includes, for example, information about the plan's Star Ratings.
- **Information about our network pharmacies.** You have the right to get information about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make 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.** You can get an advance directive 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.
- **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 who can make decisions for you if you can't. You may want to give copies to close friends or family members. 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**.

- The hospital 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 state agency. For contact information on the State Medical Assistance Office in your state, please refer to **Exhibit C** or call Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY/TDD 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 Care** at 1-833-837-4309, (TTY/TDD users should call 711), with questions. Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. You can **call the State Health Insurance Assistance Program (SHIP)**. For details, 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/TDD 1-877-486-2048).

Section 1.8 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 Care** at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

- You can **call the State Health Insurance Assistance Program (SHIP) in your state**. For details, go to Chapter 2, Section 3, or refer to **Exhibit C** toward the back of this document.
- 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/TDD 1-877-486-2048).

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this Evidence of Coverage 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.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan membership 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 get the best care, tell your doctors and other health providers about your health problems. 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 and get an answer you can understand.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Your plan premium must be paid.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.

    - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Please remember to also notify UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.), so they will have your most up-to-date contact information on file. Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific). We need to keep your membership record up to date and know how to contact you.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- If you move *outside* of our plan service area, you cannot remain a member of our plan. Our service area includes all U.S. states, and Puerto Rico.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7

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

SECTION 1 Introduction

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

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first. Please call Navitus MedicareRx Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. We will work with you on a mutually satisfactory solution to your concern. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

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

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are 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 make things easier, this chapter:

- Uses 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. Knowing which terms to use will help you communicate more accurately to 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 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find the SHIP program for your state in **Exhibit A** (located toward the back of this document).

Medicare

You can also contact Medicare to get help. To contact Medicare:

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

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

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. Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals".**

No.

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

Coverage decisions and appeals deals with problems related to your benefits and coverage for prescription drugs, including payments. 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 prior to receiving services

A coverage decision is a decision we make about your coverage or about the amount we will pay for your prescription drugs. When we have completed the review, we give you our decision. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but 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. (For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.) 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 6 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Customer Care** at 1-833-837-4309. (TTY/TDD users should call 711). **You can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **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.
    - If you want a friend, relative, or other person to be your representative, call Customer Care 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 or on our website at https://memberportal.navitus.com. 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 us a copy of the signed form.

  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** 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

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 include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 3 and 4.

- **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. We also use the terms "List of Covered Drugs" or "Formulary".
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- 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.

Part D coverage decisions and appeals

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*. **Ask for an exception. Section 5.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 5.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

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.

Section 5.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Formulary is sometimes called asking for a **"formulary exception"**. Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception"**. Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception"**.

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception". An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. 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 Formulary.** If we agree to cover a drug not on the Formulary, you will need to pay the cost-sharing amount that applies to drugs in Tier 3. You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our Formulary. 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 Formulary is in one of four 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.
    - If our formulary 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).
    - 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.
    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
    - You cannot ask us to change the cost-sharing tier for any drug in Tier 4 designated as specialty.
    - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

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

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

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

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage" decision.

"Standard coverage decisions" are made within **72 hours** after we receive your doctor's statement. **"Fast coverage decisions"** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a "fast coverage decision". **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- 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 give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "fast coverage decision".

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription drug you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which is available on our website. Chapter 2 has contact information.

  For electronic submission, you can go to our website (https://memberportal.navitus.com). Complete the *Request for Coverage Determination* form, located under *My Plan, Forms and Documents*. **Note:** If attachments need to be submitted, please fax, or mail the form and supporting documentation. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the "supporting statement",** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a "fast coverage decision"

- We must generally give you our answer within **24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. 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.
- **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

- We must generally give you our answer **within 72 hours** after we receive your request.

  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. 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.
- **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 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.
- **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.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.5 Step-by-step: How to make a Level 1 appeal

Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination"**. A "fast appeal" is also called an **"expedited redetermination"**.

Step 1: Decide if you need a "standard appeal" or a "fast appeal".

A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal".
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a "fast appeal".

- **For standard appeals, submit a written request,** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call Navitus MedicareRx Customer Care at (1-833-837-4309)**. Chapter 2 also has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **For electronic submission,** you can go to our website (https://memberportal.navitus.com). Complete the *Request for Coverage Determination* form, located under *My Plan, Forms and Documents*. **Note:** If attachments need to be submitted, please fax, or mail the form and supporting documentation. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it (*good cause*), explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of *good cause* may include 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 and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

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

Deadlines for a "fast appeal"

- For fast appeals, 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. Section 5.6 explains the Level 2 appeal 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 for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If 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. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** 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" about payment for a drug you have already bought:

- We must give you our answer **within 14 calendar days** after we receive your request.

  - o 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.

- **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.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 5.6 Step-by-step: How to make a Level 2 appeal

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

The **Independent Review Entity is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your "case file". **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for "fast appeal"

- If your health requires it, ask the independent review organization for a "fast appeal".
- If the organization agrees to give you a "fast appeal", the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for "standard appeal"

- For standard appeals, 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 yet received. 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.

Step 3: The independent review organization gives you their answer.

For "fast appeals":

- **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.

For "standard appeals":

- **If the independent review organization says yes to part or all of your 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 says yes to part or all of your 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 part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision". It is also called "turning down your appeal".) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. 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.

- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- 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	**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**. 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. The notice you get will tell you what to do for a Level 4 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**. 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 may 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 will tell you whether the rules allow you to go on to a Level 5 appeal. It 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.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Did someone not respect your right to privacy or shared confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Care or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal", and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

Legal Terms
• A **"Complaint"** is also called a **"grievance".** • **"Making a complaint"** is also called **"filing a grievance".** • "**Using the process for complaints"** is also called "**using the process for filing a grievance".** • A "**fast complaint**" is also called an "**expedited grievance".**

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Navitus MedicareRx Customer Care is the first step.** Please contact our Customer Care number at 1-833-837-4309. TTY/TDD users should call 711. Navitus MedicareRx Customer Care are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. If there is anything else you need to do, Customer Care will let you know.
- **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.
- **When a written complaint is received** in any department of Navitus Health Solutions, it is immediately forwarded to the Navitus MedicareRx Grievance and Appeals Department. All information related to the complaint is collected. You will be advised of the decision no later than 30 calendar days after the date the oral or written complaint is received. Navitus MedicareRx may extend the 30-calendar day timeframe by up to an additional 14 calendar days. Extensions may be given if you request the extension, or if the Grievance and Appeals Department justifies a need for more information. We must inform you of the status of the grievance within 30 days of receipt of the complaint.
    - **You may file for a faster response time** when sending an expedited complaint. This request may be filed either verbally or in writing. The same procedures apply for documentation as with standard complaints. However, the Grievance and Appeals Department must notify the member of the decision within 24 hours of receipt of the complaint. The decision is usually presented verbally to the member. Navitus MedicareRx then sends written notice of the decision within three (3) calendar days of the oral notification.
- **Whether you call or write, you should contact Customer Care right away** Please contact Customer Care at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. 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**.
- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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.
- **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 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**.
- **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 include our reasons in our response to you.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization**. 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. Chapter 2 has contact information.

-Or-

- **You can make your complaint to both the Quality Improvement Organization and Navitus MedicareRx at the same time.** Please refer to **Exhibit B** for the name and contact information of the specific Quality Improvement Organization in your area.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about Navitus MedicareRx directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provider information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your prescription drugs and you will continue to pay your cost share until your membership ends.

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

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during Medicare's **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period is from** October 15 to December 7.
  - You also have a specific open enrollment period for your plan outside of Medicare's Annual Enrollment Period noted above.
- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to **opt out of Navitus MedicareRx to join a new plan**, you can choose any of the following types of plans:
  - Another Medicare prescription drug plan.
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - *– or –* A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include their own Part D prescription drug coverage.

    If you enroll in most Medicare health plans, you will be disenrolled from Navitus MedicareRx when your new plan's coverage begins. However, if you choose a Private

Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan, but your membership in our Navitus MedicareRx drug coverage will not end. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage. (Your group benefits administrator can best explain your options and the implications of leaving this plan.) It is important to call or send a written request to disenroll to your benefits administrator.

- **To request not to be enrolled by this process,** please contact the UC Retirement Administration Service Center (RASC) at (800) 888-8267 (in U.S.) or (510) 987-0200 (from outside the U.S.), Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific), to complete the disenrollment process.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Navitus MedicareRx may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - If you have moved out of your plan's service area of all U.S. states, and Puerto Rico.
  - If you have Medicaid.
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states.
  - **Note**: If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.
- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users call 1-

877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- o Another Medicare prescription drug plan.
- o Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

  - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- o *– or –* A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
  - If you enroll in most Medicare health plans, you will automatically be disenrolled from Navitus MedicareRx when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan, but your membership in our Navitus MedicareRx drug coverage will not end. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage. (Your group benefits administrator can best explain your options and the implications of leaving this plan.) It is important to call or send a written request to disenroll to your benefits administrator.

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

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **To request not to be enrolled by this process,** please contact the UC Retirement Administration Service Center (RASC) at (800) 888-8267 (in U.S.) or (510) 987-0200 (from outside the U.S.), Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific), to complete the disenrollment process.
- **Call Customer Care** at 1-833-837-4309. (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.
- Find the information in the ***Medicare & You 2023*** handbook.

- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY/TDD 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

If you are considering ending your Part D membership with Navitus MedicareRx, please first contact RASC at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.), to talk about how this may affect your UC Medicare Supplement PPO plan coverage.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	**This is what you should do:**
• Another Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. It is important to call or send a written request to disenroll to your benefits administrator. You will automatically be disenrolled from Navitus MedicareRx when your new plan's coverage begins.
• A Medicare health plan.	• Enroll in the Medicare health plan by December 7. With most Medicare health plans, you will automatically be disenrolled from Navitus MedicareRx when your new plan's coverage begins. However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan, but your membership in our Navitus MedicareRx drug coverage will not end. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage. (Your group benefits administrator can best explain your options and the implications of leaving this plan.) To ask to be disenrolled, you must call or send a written request to disenroll to your benefits administrator or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY/TDD users should call 1-877-486-2048).

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan.	• **It is important to call or send a written request to disenroll to your benefits administrator.** Contact Customer Care if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY/TDD users should call 1-877-486-2048.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your prescription drugs through our plan.

- **Continue to use our network, mail order and specialty pharmacies to get your prescriptions filled.**

SECTION 5 Navitus MedicareRx must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

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

- If you no longer have Medicare Part A or Part B.
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
    - If you move or take a long trip, call Customer Care to find out if the place you are moving or traveling to is in our plan’s area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie 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 our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership 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 do not pay the plan premiums for 3 months.
    - We must notify you in writing that you have 3 months to pay the plan premium before we end your membership.
- 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 call Customer Care. It is important to call or send a written request to your benefits administrator if you want to disenroll from Navitus MedicareRx.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Navitus MedicareRx is not allowed to ask you to leave our plan for any health-related reason.

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, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY/TDD 1-877-486-2048.

Section 5.3 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 file a grievance or can make a complaint about our decision to end your membership.

CHAPTER 9
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* 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. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, 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/TDD 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 Care. If you have a complaint, such as a problem with wheelchair access, Customer Care 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, Navitus MedicareRx, 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.

CHAPTER 10:
Definitions of important words

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received.

Annual Enrollment Period (Original Medicare) – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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 $7,400 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-A SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for prescription drugs after you pay any deductible, if applicable.

Complaint – The formal name for "making a complaint" is "filing a grievance". The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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 (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) 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.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of four 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 document.

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

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

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

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.

Deductible – The amount you must pay for prescriptions before our plan pays, if applicable.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispense as Written (DAW) – If a brand drug is requested when a generic alternative is on the formulary, members will be charged the brand copay along with the difference in price between the brand and generic drug.

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. 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 and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to 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 our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare or a State 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 our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

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

Initial Coverage 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 $4,660.

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. 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.

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. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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).

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 i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP) 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**.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

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, Special Needs 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 our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. 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 does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our 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 (LTC) 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. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states.

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress.

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.

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. 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.

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 you must live to join a particular prescription drug plan. 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.

Standard Cost Sharing – Standard cost sharing is cost sharing offered at a network pharmacy.

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.

Exhibit A - Listing of State Health Insurance Assistance Programs (SHIPs)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

TTY/TDD numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY/TDD number indicated, you may try 711.

Anexo A: Lista de Programas Estatales de Asistencia sobre Seguro Médico (State Health Insurance Assistance Program, SHIP)

SHIP es un programa estatal que recibe dinero del gobierno federal para brindar asesoramiento local gratuito sobre seguros de salud a personas con Medicare.

Los números TTY/TDD requieren equipos telefónicos especiales y son solo para personas que tienen dificultades auditivas o del habla. Si no se indica un número TTY/TDD, puede intentar llamar al 711.

State	Agency Name/Address	Contact Information
Alabama	State Health Insurance Assistance Program (SHIP) 201 Monroe St, Ste 350 Montgomery AL 36104	Toll Free: 1-800-243-5463 Local: 1-334-242-5743 Fax: 1-334-242-5594
Website: http://www.alabamaageline.gov/		
Alaska	Alaska Medicare Information Office (SHIP) 550 W. 8th Ave Anchorage AK 99501	Toll Free (within AK): 1-800-478-6065 Local (in Anchorage): 1-907-269-3680 Outside AK: Call Anchorage TTY/TDD: 1-800-770-8973
Website: http://www.medicare.alaska.gov		
Arizona	State Health Insurance Assistance Program (SHIP) 1789 W. Jefferson St #950A Phoenix AZ 85007	Toll Free: 1-800-432-4040 (leave message) Local: 1-602-542-4446
Website: https://des.az.gov/services/older-adults/medicare-assistance		
Arkansas	Senior Health Insurance Information Program (SHIP) 1200 W. 3rd St Little Rock AR 72201-1904	Toll Free: 1-800-224-6330 Local: 1-501-371-2782 TTY/TDD: 1-501-371-2782
Website: https://insurance.arkansas.gov/pages/consumer-services/senior-health/		

State	Agency Name/Address	Contact Information
California	California Health Insurance Counseling and Advocacy Program (HICAP) 1300 National Dr, Ste 200 Sacramento CA 95834	Toll Free (within CA): 1-800-434-0222 Toll Free (outside CA): 1-800-677-1116 TTY/TDD: 1-800-735-2929
Website: https://www.aging.ca.gov/hicap/		
Colorado	State Health Insurance Assistance Program 1560 Broadway, Ste 850 Denver CO 80202	Toll Free: 1-888-696-7213 Local: 1-303-894-7855 TTY/TDD: 1-303-894-7880 Spanish: 1-866-665-9668
Website: https://www.colorado.gov/dora/senior-healthcare-medicare		
Connecticut	Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES) 55 Farmington Ave Hartford CT 06105-3730	Toll Free (within CT): 1-800-994-9422 Outside CT: 1-860-424-5274
Website: http://www.ct.gov/agingservices		
Delaware	Delaware Medicare Assistance Bureau (DMAB) 841 Silverlake Blvd Dover DE 19904	Toll Free: 1-800-336-9500 Local: 1-302-674-7364
Website: https://insurance.delaware.gov/divisions/dmab/		
District of Columbia	Health Insurance Counseling Project (HICP) 500 K Street NE Washington DC 20002	Local: 1-202-727-8370 Fax: 1-202-741-5885
Website: https://dcoa.dc.gov/service/health-insurance-counseling		
Florida	Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, Ste 270 Tallahassee FL 32399	Toll Free: 1-800-963-5337 TYY:1-800-955-8770 Fax: 1-850-414-2150
Website: www.floridashine.org		
Georgia	GeorgiaCares 2 Peachtree St NW, 33rd Floor Atlanta GA 30303	Toll free: 1-866-552-4464 (Option 4)
Website: www.mygeorgiacares.org		
Hawaii	Hawaii State Health Insurance Assistance Program (SHIP) No 1 Capitol District 250 South Hotel St, Ste 406 Honolulu HI 96813-2831	On the island of Oahu: 1-808-586-7299 Neighbor islands Toll Free: 1-888-875-9229 TTY/TDD: 1-866-810-4379
Website: www.hawaiiship.org		

State	Agency Name/Address	Contact Information
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) PO Box 83720 Boise ID 83720-0043	Toll Free: 1-800-247-4422 Local: 1-208-334-4250 Fax: 1-208-334-4389
Website: https://doi.idaho.gov/SHIBA/default		
Illinois	Senior Health Insurance Program (SHIP) One Natural Resources Way #100 Springfield IL 62702-1271	Toll Free: 1-800-252-8966 TTY/TDD: 1-888-206-1327
Website: www.illinois.gov/aging/ship/Pages/default.aspx		
Indiana	State Health Insurance Assistance Program (SHIP) 311 W. Washington St, Ste 300 Indianapolis IN 46204-2787	Toll Free: 1-800-452-4800 TYY: 1-866-846-0139
Website: www.in.gov/idoi/2495.htm		
Iowa	Senior Health Insurance Information Program (SHIIP) 601 Locust St, 4th Floor Des Moines IA 50309-3738	Toll Free: 1-800-351-4664 TTY/TDD: 1-800-735-2942
Website: https://shiip.iowa.gov/		
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Ste 612 Topeka KS 66603	Toll Free: 1-800-860-5260 TTY/TDD: 1-800-766-3777 Fax: 1-785-296-0256
Website: https://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick		
Kentucky	State Health Insurance Assistance Program (SHIP) 275 E. Main St 3E-E Frankfort KY 40621	Toll Free: 1-877-293-7447 (Option #2) Local (DAIL): 1-502-564-6930 (Ask for a SHIP counselor) TTY/TDD: 1-888-642-1137
Website: https://chfs.ky.gov/agencies/dail/Pages/ship.aspx		
Louisiana	Senior Health Insurance Information Program (SHIIP) 1702 N 3rd Baton Rouge LA 70802	Toll Free: 1-800-259-5300 Local: 1-225-342-5301
Website: www.ldi.la.gov/consumers/senior-health-shiip		
Maine	Office of Aging and Disability Services 41 Anthony Ave Augusta ME 04333	Toll Free: 1-800-262-2232
Website: http://www.maine.gov/dhhs/oads/community-support/ship.html		
Maryland	Senior Health Insurance Assistance Program (SHIP) 301 W. Preston St, Ste 1007 Baltimore MD 21201	Toll Free: 1-800-243-3425 Local: 1-410-767-1100
Website: http://www.aging.maryland.gov/Pages/StateHealthInsuranceProgram.aspx		

State	Agency Name/Address	Contact Information
Massachusetts	Serving Health Insurance Needs of Elders (SHINE) 1 Ashburton Pl, 5th Floor Boston MA 02108	Toll Free: 1-800-243-4636 TTY/TDD: 1-877-610-0241
Website: https://www.mass.gov/health-insurance-counseling		
Michigan	Medicare/Medicaid Assistance Program (MMAP) 6105 W. St Joseph Hwy, Ste 204 Lansing MI 48917	Toll Free: 1-800-803-7174
Website: http://mmapinc.org/		
Minnesota	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar St St. Paul MN 55155	Toll Free: 1-800-333-2433 TTY/TDD: 1-800-627-3529
Website: https://www.minnesotahelp.info/index		
Mississippi	State Health Insurance Assistance Program 200 S Lamar St. Jackson, MS 39201	Toll Free: 1-844-822-4622 Local: 1-601-359-4500
Website: http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/		
Missouri	CLAIM, State Health Insurance Assistance Program (SHIP) 200 N. Keene St., Ste. 101 Columbia, MO 65201	Toll Free: 1-800-390-3330 Local: 1-573-817-8320
Website: www.missouriclaim.org		
Montana	Montana State Health Insurance Assistance Program (SHIP) 2030 11th Ave Helena MT 59604	Toll Free: 1-800-551-3191 1-406-444-2590
Website: http://dphhs.mt.gov/SLTC/aging/SHIP		
Nebraska	Nebraska Senior Health Insurance Information Program 1033 O St. Suite 307 Lincoln, NE 68508	Toll Free: 1-800-234-7119 Local: 1-402-471-2201 TTY/TDD: 1-800-833-7352
Website: www.doi.nebraska.gov/shiip/		
Nevada	State Health Insurance Assistance Program 3416 Goni Road Suite D-132 Carson City NV 89706	Toll Free: 1-800-307-4444 Local: 1-775-687-4210
Website: http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/		
New Hampshire	NH ServiceLink Resource Center 2nd Industrial Park Drive Concord, NH 03302	Toll Free: 1-866-634-9412 Local: 1-603-228-6625 TTY/TDD: 1-800-735-2964
Website: https://www.servicelink.nh.gov/		

State	Agency Name/Address	Contact Information
New Jersey	State Health Insurance Assistance Program PO Box 715 Trenton NJ 08625-0715	Toll Free: 1-877-222-3737 TTY/TDD: 1-877-486-2048
Website: www.state.nj.us/humanservices/doas/services/ship/		
New Mexico	New Mexico ADRC 2550 Cerrillos Road Santa Fe NM 87505	Toll Free: 1-800-432-2080 Local: 1-505-476-4799 TTY/TDD: 1-505-476-4937
Website: http://www.nmaging.state.nm.us/		
New York	Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza 4th Floor Albany NY 12223	Toll Free: 1-800-701-0501 Local: 1-800-342-9871
Website: https://www.shiphelp.org/about-medicare/regional-ship-location/new-york		
North Carolina	Seniors' Health Insurance Information Program 325 N Salisbury St Raleigh, NC 27603	Toll Free: 1-855-408-1212 Local: 1-919-807-6900 TTY/TDD: 1-800-735-2962
Website: www.ncdoi.com/SHIIP/Default.aspx		
North Dakota	State Health Insurance Counseling Program 600 E Boulevard Ave Bismarck, ND 58505	Toll Free: 1-888-575-6611 Local: 1-701-328-2440 TTY/TDD: 1-800-366-6888
Website: www.nd.gov/ndins/shic		
Ohio	Ohio Senior Health Insurance Information Program 50 W. Town St 3rd Floor, Ste 300 Columbus OH 43215	Toll Free:1-800-686-1578 Local: 1-614-644-2658 TTY/TDD: 1-614-644-3745
Website: http://www.insurance.ohio.gov/Pages/default.aspx		
Oklahoma	Medicare Assistance Program 5 Corporate Plaza 3625 NW 56th St, Ste 100 Oklahoma City, OK 73112	Toll Free: 1-800-763-2828 Local: 1-405-521-2828
Website: www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html		
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter St NE Salem OR 97309-2555	Toll Free: 1-800-722-4134 TTY/TDD: 1-800-735-2900
Website: https://healthcare.oregon.gov/shiba/pages/index.aspx		
Pennsylvania	APPRISE Pennsylvania State Health Assistance Program 600 S Wycombe Ave, Yeadon, PA 19050	Toll Free: 1-800-783-7067 Local: 1-484-494-3769
Website: http://www.aging.pa.gov/aging-services/insurance/Pages/default.aspx		

State	Agency Name/Address	Contact Information
Puerto Rico	State Health Insurance Assistance Program San Juan PR 00907	Toll Free: 1-877-725-4300 TTY/TDD: 1-787-919-7291
Website: http://www.oppea.pr.gov/		
Rhode Island	Senior Health Insurance Program 57 Howard Ave Louis Pasteur Bldg. 2nd Floor Cranston RI 02920	Toll Free: 1-888-884-8721 Local: 1-401-462-0510 TTY/TDD: 1-401-462-0740
Website: www.dea.ri.gov/insurance/		
South Carolina	State Health Insurance Assistance Program (SHIP) 1301 Gervais St, Ste 350 Columbus SC 29201	Toll Free: 1-800-868-9095 Local: 1-803-734-9900
Website: https://aging.sc.gov/programs-and-initiatives		
South Dakota	Senior Health Information & Insurance Education (SHIINE) 2300 W 46th St Sioux Falls SD 57105	Toll Free: 1-800-536-8197 Local: 1-605-333-3314
Website: www.shiine.net		
Tennessee	State Health Insurance Assistance Program 502 Deaderick St, 9th Floor Nashville TN, 37243-0860	Toll Free: 1-877-801-0044 Local: 1-615-741-2056 TTY/TDD: 1-615-532-3893
Website: http://tnmedicarehelp.com/		
Texas	Health Information Counseling and Advocacy Program (HICAP) 701 W. 51st St Austin TX 78751	Toll Free: 1-800-252-9240 TTY/TDD: 1-800-735-2989
Website: https://hhs.texas.gov/services/health/medicare		
Utah	Senior Health Insurance Information Program 195 N. 1950 W Salt Lake City UT 84116	Toll Free: 1-800-541-7735 Local: 1-801-538-4171
Website: https://daas.utah.gov/seniors/		
Vermont	State Health Insurance Assistance Program 476 Main St Ste #3 Winooski VT 05404	Toll Free: 1-800-642-5119 Local: 1-802-578-7094
Website: https://www.vermont4a.org/		
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Ave, Ste 100 Henrico VA 23229	Toll Free: 1-800-552-3402 Local: 1-804-662-9333
Website: www.vda.virginia.gov/vicap.asp		
Washington	Statewide Health Insurance Benefits Advisors (SHIBA) PO Box 40255 Olympia WA 98504-0255	Toll Free: 1-800-562-6900 TTY/TDD: 1-360-586-0241

State	Agency Name/Address	Contact Information
Website: www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/		
West Virginia	West Virginia State Health Insurance Assistance Program 1900 Kanawha Blvd E Charleston WV 25305	Toll Free: 1-877-987-4463 Local: 1-304-558-3317
Website: www.wvship.org/AboutWVSHIP/tabid/132/Default.aspx		
Wisconsin	Wisconsin State Health Insurance Assistance Program (SHIP) 1 W. Wilson St Madison WI 53703	Toll Free: 1-800-242-1060 Local: 1-608-266-1865 TTY/TDD: 1-866-701-1251
Website: www.dhs.wisconsin.gov/benefit-specialists/ship.htm		
Wyoming	Wyoming State Health Insurance Assistance Program 106 West Adams Ave Riverton WY 82501	Toll Free: 1-800-856-4398 Local: 1-307-856-6880
Website: www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program		

Exhibit B - Listing of Quality Improvement Organizations (QIOs)

Region	Address	Contact
1 **(CT, ME, MA, NH, RI, VT)**	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-319-8452 833-868-4055 (fax) 855-843-4776 TTY/TDD
2 **(NJ, NY, PR, VI)**	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	866-815-5440 833-868-4056 (fax) 866-868-2289 TTY/TDD
3 **(DE, DC, MD, PA, VA, WV)**	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	888-396-4646 833-868-4057 (fax) 888-985-2660 TTY/TDD
4 **(AL, FL, GA, KY, MS, NC, SC, TN)**	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	888-317-0751 833-868-4058 (fax) 855-843-4776 TTY/TDD
5 **(IL, IN, MI, MN, OH, WI)**	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	888-524-9900 833-868-4059 (fax) 888-985-8775 TTY/TDD
6 **(AR, LA, NM, OK, TX)**	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	888-315-0636 833-868-4060 (fax) 855-843-4776 TTY/TDD
7 **(IA, KS, MO, NE)**	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	888-755-5580 833-868-4061 (fax) 888-985-9295 TTY/TDD
8 **(CO, MT, ND, SD, UT, WY)**	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-317-0891 833-868-4062 (fax) 855-843-4776 TTY/TDD
9 **(AZ, CA, HI, NV)**	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	877-588-1123 833-868-4063 (fax) 855-887-6668 TTY/TDD
10 **(AK, ID, OR, WA)**	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-305-6759 833-868-4064 (fax) 855-843-4776 TTY/TDD

TTY/TDD numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking

Exhibit C - Listing of State Medical Assistance Offices (Medicaid)

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
Alabama	Medicaid Agency of Alabama	501 Dexter Ave PO Box 5624 Montgomery AL 36103-5624	1-800-362-1504 www.medicaid.alabama.gov
Alaska	Alaska Department of Health and Social Services	350 Main St Rm 304 PO Box 110640 Juneau AK 99811-0640	1-800-780-9972 http://dhss.alaska.gov
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	801 E. Jefferson St Phoenix AZ 85034	1-855-432-7587 www.azahcccs.gov
Arkansas	Arkansas Medicaid	PO Box 1437 Slot S401 Little Rock AR 72203-1437	1-800-482-8988 1-800-285-1131 x26789 (TTY/TDD) * https://medicaid.mmis.arkansas.gov
California	Medi-Cal	PO Box 997417 MS 4607 Sacramento CA 95899-7417	1-800-541-5555 1-916-636-1980 (outside California) https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx
Colorado	Health First Colorado	1570 Grant St Denver CO 80203-1818	1-800-221-3943 TTY/TDD: 711 www.colorado.gov/hcpf
Connecticut	Husky Health	55 Farmington Ave Hartford CT 06105-3730	1-877-284-8759 1-866-492-5276 (TTY/TDD) * http://www.ct.gov/hh/
Delaware	Diamond State Health	1901 N. Dupont Hwy New Castle DE 19720	1-866-843-7212 1-302-571-4900 http://www.dhss.delaware.gov/dss/medicaid.html
District of Columbia	DC Medicaid	441 4th St NW 900S Washington DC 20001	1-202-727-5355 www.dc-medicaid.com
Florida	Statewide Medicaid Managed Care	2727 Mahan Dr Mail Stop #8 Tallahassee FL 32308	1-877-254-1055 1-866-467-4970 (TTY/TDD) * www.fdhc.state.fl.us/Medicaid
Georgia	Georgia Medicaid	2 Peachtree St NW Atlanta GA 30303	1-866-211-0950 https://dch.georgia.gov/medicaid

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
Hawaii	Hawaii QUEST	801 Dillingham Blvd 3rd Floor Honolulu HI 96817	Oahu: 1-808-524-3370 TTY/TDD: 1-808-692-7182* Neighbor Islands: 1-800-316-8005 TTY/TDD 1-800-603-1201 * https://medquest.hawaii.gov
Idaho	Idaho Medicaid	1720 N Westgate Dr Boise ID 83704	1-877-456-1233 1-208-334-6801 (TTY/TDD) * http://www.medicaid.idaho.gov/
Illinois	HFS Medical Benefits	201 S. Grand Ave E. 2nd Springfield IL 62704-0001	1-800-843-6154 1-800-447-6404 (TTY/TDD) * http://www.illinois.gov/hfs/
Indiana	Hoosier Healthwise	PO Box 1810 Marion IN 46952	1-800-457-4584 https://fssabenefits.in.gov
Iowa	IA Health Link	1305 E Walnut St Des Moines IA 50319	1-800-338-8366 1-800-735-2942 (TTY/TDD) * http://dhs.iowa.gov/iahealthlink
Kansas	KanCare	900 SW Jackson St Ste 900N Topeka KS 66612	1-800-792-4884 www.kancare.ks.gov
Kentucky	Kentucky Medicaid	275 E Main St 6W-A Frankfurt KY 40602	1-855-306-8959 https://chfs.ky.gov/
Louisiana	Healthy Louisiana	PO Box 629 Baton Rouge LA 70821-0629	1-888-342-6207 1-855-526-3346 (TTY/TDD) * www.bayouhealth.com
Maine	MaineCare	114 Corn Shop Ln Farmington ME 04938	1-855-797-4357 TTY/TDD: 711 * https://www.maine.gov/DHHS/oms
Maryland	Maryland Medicaid	201 W Preston St Baltimore MD 21201	1-877-463-3464 1-410-767-6500 mmcp.dhmh.maryland.gov
Massachusetts	MassHealth	PO Box 290794 Charleston MA 02129	1-800-841-2900 1-800-497-4648 (TTY/TDD) * www.mass.gov/masshealth
Michigan	Michigan Medicaid Program	333 S Grand Ave PO Box 30195 Lansing MI 48909	1-800-642-3195 1-800-649-3777 (TTY/TDD) * www.michigan.gov/medicaid
Minnesota	MinnesotaCare	PO Box 64838 St Paul MN 55164	1-800-657-3672 http://mn.gov/dhs
Mississippi	Mississippi Medicaid	550 High St Ste 1000 Jackson MS 39201-1399	1-800-421-2408 www.medicaid.ms.gov

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
Missouri	MO HealthNet	615 Howerton Ct PO Box 6500 Jefferson City MO 65102-6500	1-800-392-2161 www.dss.mo.gov/fsd
Montana	Montana Medicaid	1400 Broadway Cogswell Bldg Helena MT 59620	1-800-362-8312 https://apply.mt.gov
Nebraska	Access Nebraska	301 Centennial Mall S. PO Box 95026 Lincoln NE 68509	1-855-632-7633 1-402-471-9570 (TTY/TDD) * www.accessnebraska.ne.gov
Nevada	Nevada Medicaid	1210 S. Valley View Suite 104 Las Vegas NV 89102	1-800-992-0900 https://dwss.nv.gov/
New Hampshire	NH Health Protection Program	129 Pleasant St Concord NH 03301-3852	1-888-901-4999 1-800-735-2964 (TTY/TDD) * http://www.dhhs.nh.gov/ombp/
New Jersey	NJ FamilyCare	7 Quakerbridge Plaza PO Box 712 Trenton NJ 08619	1-800-356-1561 http://www.state.nj.us/humanservices
New Mexico	Centennial Care	PO Box 2348 Santa Fe NM 87504-2348	1-800-283-4465 http://www.hsd.state.nm.us/
New York	New York Medicaid	1466 Corning Tower Albany NY 12237	1-800-541-2831 www.health.ny.gov
North Carolina	North Carolina Medicaid	220 Swinburne St PO Box 46833 Raleigh NC 27620	1-800-662-7030 1-877-733-4851 (TTY/TDD) * https://dma.ncdhhs.gov/medicaid/
North Dakota	North Dakota Medicaid	600 E. Boulevard Ave Dept 325 Bismarck, ND 58505-0250	1-844-854-4825 1-800-366-6888 (TTY/TDD) * http://www.nd.gov/dhs/eligibility/
Ohio	Ohio Medicaid	50 W. Town St Ste 400 Columbus OH 43215	1-800-324-8680 http://www.medicaid.ohio.gov
Oklahoma	SoonerCare	4345 N. Lincoln Blvd Oklahoma City OK 73105	1-800-987-7767 http://www.okhca.org/

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
Oregon	Oregon Health Plan	500 Summer St NE Salem OR 97301	1-800-699-9075 http://healthcare.oregon.gov/
Pennsylvania	Pennsylvania Medicaid	625 Forester St Rm 515 PO Box 2675 Harrisburg PA 17105	1-800-692-7462 1-717-705-7103 (TTY/TDD) * http://www.dhs.pa.gov/citizens/healthcaremedicalassistance/
Puerto Rico	Puerto Rico Medicaid	PO Box 70184 San Juan PR 00936	1-787-765-6000 www.medicaid.pr.gov
Rhode Island	Rhody Health Options	57 Howard Ave Cranston RI 02920	1-800-984-8989 1-401-462-0740 (TTY/TDD) * http://www.eohhs.ri.gov/
South Carolina	Healthy Connections	PO Box 100101 Columbia SC 29202	1-888-549-0820 www.scdhhs.gov
South Dakota	South Dakota Medicaid	700 Governors Dr Pierre SD 57501	1-800-226-1033 http://dss.sd.gov/medicaid/
Tennessee	TennCare	310 Great Circle Rd Nashville TN 37243	1-800-342-3145 1-877-779-3103 (TTY/TDD) * www.tn.gov/tenncare/
Texas	Texas Medicaid	4900 N. Lamar Blvd Austin TX 78751	1-800-252-8263 1-512-424-6597 (TTY/TDD) * www.yourtexasbenefits.com
Utah	Utah Medicaid	288 N. 1460 West PO Box 143106 Salt Lake City UT 84114	1-800-662-9651 https://medicaid.utah.gov/
Vermont	Vermont Medicaid	103 S. Main St Waterbury VT 05671-0204	1-800-250-8427 http://dcf.vermont.gov/benefits/MABD
Virginia	Virginia Medicaid	600 E. Broad St Ste 1300 Richmond VA 23219	1-804-786-7933 1-800-343-0634 (TTY/TDD) * http://www.dmas.virginia.gov/
Washington	Washington Apple Health	PO Box 45502 Olympia WA 98504-5502	1-800-562-3022 1-360-586-0226 (TTY/TDD) * http://www.hca.wa.gov/Medicaid

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
West Virginia	WV Medicaid	350 Capitol St Rm 251 Charleston WV 25301	1-888-483-0797 http://www.dhhr.wv.gov/
Wisconsin	ForwardHealth	1 West Wilson St Madison WI 53703	1-800-362-3002 1-888-701-1251 (TTY/TDD) * www.forwardhealth.wi.gov
Wyoming	Wyoming Medicaid	401 Hathaway Bldg Cheyenne WY 82002	1-866-571-0944 https://health.wyo.gov

*This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Exhibit D - Listing of State Pharmaceutical Assistance Programs (SPAPs)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Colorado	Colorado Bridging the Gap	Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246	1-303-692-2716 1-303-692-2783
https://www.colorado.gov			
Connecticut	Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program (ConnPACE)	PO Box 5011 Harford CT 06102	1-860-269-2029 (Hartford/Farmington and out-of-state) 1-800-423-5026 (in-state only)
https://portal.ct.gov/dors			
Delaware	Delaware Prescription Assistance Program	PO Box 950 New Castle DE 19720	1-800-996-9969 Ext:2
https://www.dhss.delaware.gov/dhss/dmma/dpap.html			
Idaho	IdaGAP	PO Box 83720 Boise ID 83720	1-208-334-5612
http://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment			
Indiana	HoosierRx	402 W. Washington St Room W374, MS07 Indianapolis IN 46204	1-866-267-4679
https://www.payingforseniorcare.com/pharmaceutical-assistance/in-hoosierrx.html			
Massachusetts	Massachusetts Prescription Advantage	PO Box 15153 Worcester MA 01615	1-800-243-4636 Ext: 2 TTY/TDD (877) 610-0241
https://www.mass.gov/prescription-drug-assistance			
Maryland	Maryland SPAP	c/o Pool Administrators 628 Hebron Ave Ste 502 Glastonbury CT 06033	1-800-551-5995 TTY/TDD 1-800-877-5156
http://marylandspdap.com/			
Maine	MaineCare Services	242 State St Augusta ME 04333	1-866-796-2463
https://www.maine.gov/dhhs/oads/community-support/medicare-assistance.html			
Missouri	Missouri Rx Plan	PO Box 6500 Jefferson City MO 65102	1-800-375-1406
https://www.payingforseniorcare.com/pharmaceutical-assistance/mo-missouri-rx-plan.html			

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Montana	Montana Big Sky Rx Program	PO Box 202915 Helena MT 59620	1-866-369-1233
https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky			
North Carolina	North Carolina SPAP	1902 Mail Service Center Raleigh NC 27699	1-877-466-2232
https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html			
New Jersey	NJ Senior Gold Prescription Discount Program	PO Box 715 Trenton NJ 08625	1-800-792-9745
https://www.state.nj.us/humanservices/doas/services/seniorgold/			
Nevada	Nevada Senior Rx	3416 Goni Road Ste D-132 Carson City NV 89706	1-866-303-6323 Option 2 702-486-4307
http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/			
New York	New York EPIC	PO Box 15018 Albany NY 12212	1-800-332-3742 http://www.health.ny.gov/health_care/epic/
https://www.health.ny.gov/health_care/epic/			
Pennsylvania	PACE	PO Box 8806 Harrisburg PA 17105	1-800-225-7223
https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx			
Rhode Island	RIPAE	74 West Rd Cranston RI 02920	1-401-462-3000
https://www.payingforseniorcare.com/pharmaceutical-assistance/ri-ripae.html			
Texas	Texas KHC	PO Box 149347 Austin TX 78714	1-800-222-3986
https://hhs.texas.gov/services/health/kidney-health-care			
Virginia	Virginia SPAP	109 Governor St Richmond VA 23219	1-855-362-0658
http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/			
Vermont	VPharm	312 Hurricane Ln Ste 201 Williston VT 05495	1-800-250-8427
https://www.payingforseniorcare.com/pharmaceutical-assistance/vt-vpharm-vhap-vscript.html			
Washington	Washington State Health Insurance Pool	PO Box 1090 Great Bend KS 67530	1-800-877-5187
https://www.wship.org/Default.asp			
Wisconsin	SeniorCare	PO Box 6710 Madison WI 53716	1-800-657-2038
https://www.dhs.wisconsin.gov/seniorcare/index.htm			

Exhibit E - Listing of State AIDS Drug Assistance Programs (ADAPs)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Alabama http://www.adph.org/aids/index.asp	Alabama ADAP	201 Monroe St Ste 1400 Montgomery AL 36104	1-866-574-9964
Alaska http://www.adph.org/aids/index.asp	Alaska ADAP	3601 C Street Ste 540 Anchorage AK 99503	1-907-269-8058
Arizona http://www.azdhs.gov/phs/hiv/adap/	Arizona ADAP	150 N. 18th Ave, Ste 110 Phoenix AZ 85007	1-800-334-1540
Arkansas http://www.healthy.arkansas.gov/programsServices/infectiousDisease/	Arkansas ADAP	4815 W. Markham Little Rock AR 72205	1-800-232-4636
California https://www.cdph.ca.gov/Programs/CID/DOA/pages/OA_adap_eligibility.aspx	California ADAP	1616 Capitol Ave, Ste 616 Sacramento CA 95814	1-888-311-7632
Colorado https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap	Colorado ADAP	4300 Cherry Creek Dr South Denver CO 80246	1-303-692-2716
Connecticut http://www.ct.gov/dss/lib/dss/PDFs/CADAPapp03.pdf	Connecticut ADAP	25 Sigourney St Hartford CT 06106	1-800-233-2503
Delaware http://www.dhss.delaware.gov/dph/dpc/hivtreatment.html	Delaware ADAP	540 DuPoint Hwy Dover DE 19901	1-302-739-3032
District of Columbia http://doh.dc.gov/service/dc-aids-drug-assistance-program	DC ADAP	899 North Capitol St NE Washington DC 20002	1-202-671-4900

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Florida	Florida ADAP	4052 Bald Cypress Way Tallahassee FL 32399	1-850-245-4335
http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html			
Georgia	Georgia ADAP	2 Peachtree St NW Ste 12-235 Atlanta GA 30303	1-404-657-3127
https://dph.georgia.gov/adap-program			
Hawaii	Hawaii ADAP	3627 Kilauea Ave Ste 306 Honolulu HI 96816	1-808-732-0026
http://www.idph.state.il.us/health/aids/adap.htm			
Illinois	Illinois ADAP	525 West Jefferson St 1st Floor Springfield IL 62761	1-800-547-0466
http://www.idph.state.il.us/health/aids/adap.htm			
Idaho	Idaho ADAP	450 W. State St PO Box 837220 Boise ID 83720	1-800-926-2588
http://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare			
Indiana	Ryan White Program	2 N Meridan St Indianapolis IN 46204	1-866-588-4948
https://www.in.gov/isdh/17740.htm			
Iowa	Iowa ADAP	321 E 12th St Des Moines IA 50319	1-888-346-9562
http://idph.iowa.gov/hivstdhep/hiv/support			
Kansas	Kansas ADAP	1000 SW Jackson Ste 210 Topeka KS 66612	1-785-296-8701
http://www.kdheks.gov/sti_hiv/ryan_white_care.htm			
Kentucky	Kentucky ADAP	275 E. Main St 1E-B Frankfort KY 40621	1-800-420-7431
http://chfs.ky.gov/dph/epi/hivaids/services.htm			

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Louisiana http://new.dhh.louisiana.gov/index.cfm/page/1118	Louisiana Health Access Program	1450 Poydras St Ste 2136 New Orleans LA 70112	1-504-568-7474
Maine http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml	Maine ADAP	221 State St Augusta ME 04333	1-800-851-8437
Maryland http://phpa.dhmh.maryland.gov/OIDPCS/CHCS/pages/madap.aspx	Maryland ADAP	201 W. Preston St Baltimore MD 21201	1-800-205-6308
Massachusetts http://crine.org/hdap/contact-us/	Community Research Initiative of New England/HDAP	38 Chauncy St Ste 500 Boston MA 02111	1-800-228-2714
Michigan http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982---,00.html	MiDAP	109 Michigan Ave 9th Floor Lansing MI 48913	1-888-826-6565
Minnesota https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/	MN ADAP	PO Box 64972 St Paul MN 55164	1-800-657-3761 1-800-627-3529 (TTY/TDD) *
Mississippi http://msdh.ms.gov/msdhsite/_static/14,13047,150.html	Mississippi ADAP	570 E. Woodrow Wilson PO Box 1700 Jackson MS 39215-1700	1-888-343-7373
Missouri	Missouri HIV/AIDS Case Management Program	PO Box 570 Jefferson City MO 65102-0570	1-800-785-2437

STATE	AGENCY	ADDRESS	PHONE NUMBERS
https://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php			
Montana	Montana ADAP	1400 Broadway Room C-211 Helena MT 59620	1-406-444-3565
https://adap.directory/montana			
Nebraska	Nebraska ADAP/CARE	301 Centennial Mall S. Lincoln NE 68509	1-800-782-2437
http://dhhs.ne.gov/publichealth/Pages/dpc_ryan_white.aspx			
Nevada	Nevada Ryan White	4126 Technology Way, Ste 200 Carson City NV 89706	1-877-385-2345
http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/			
New Hampshire	New Hampshire Ryan White CARE	129 Pleasant St Concord NH 03301-3852	1-800-852-3345
http://www.dhhs.nh.gov/dphs/bchs/std/care.htm			
New Jersey	NJ AIDS Drug Distribution Program	PO Box 722 Trenton NJ 08625-0722	1-877-613-4533
https://adap.directory/new-jersey			
New Mexico	NM AIDS Drug Assistance	PO Box 830 Bernalillo NM 87004	1-855-637-6574
https://nmhealth.org/about/phd/idb/hats/			
New York	HIV Uninsured CARE	PO Box 2052 Albany NY 12220-0052	1-800-542-2437 1-518-459-0121 (TTY/TDD) *
http://www.health.ny.gov/diseases/aids/general/resources/adap/			
North Carolina	NC ADAP	1902 Mail Service Center Raleigh NC 27699	1-877-466-2232
http://epi.publichealth.nc.gov/cd/hiv/adap.html			
North Dakota	Ryan White HIV/AIDS Program	2635 E. Main Ave Bismarck ND 58506	1-800-472-2180
https://www.ndhealth.gov/HIV/HIV%20Care/ADAP/ADAP.htm			

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Ohio	Ohio HIV Drug Assistance Program	246 N. High St Columbus OH 43215	1-800-777-4775
https://www.odh.ohio.gov/odhprograms/hastpac/hivcare/OHDAP/drgasst1.aspx			
Oklahoma	Oklahoma ADAP	1000 NE Tenth Rm 614 Oklahoma City OK 73117	1-800-884-1572
https://www.ok.gov/health2/documents/HIV-HDAPbrochure14.pdf			
Oregon	CAREassist	PO Box 14450 Portland OR 97293	1-800-805-2313
https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist			
Pennsylvania	Special Pharmaceutical Benefits Program	PO Box 8808 Harrisburg PA 17105-8808	1-800-922-9384
https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx			
Puerto Rico	Ryan White Program	PO Box 70184 San Juan PR 00936-8184	1-787-765-2929
http://www.salud.gov.pr/Servicios-al-Ciudadano/Pages/default.aspx			
Rhode Island	Ryan White Program	74 West Rd Ste 60 Cranston RI 02920	1-401-462-3294
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ADAPEnrollmentForm.pdf			
South Carolina	SC ADAP	PO Box 101106 Columbia SC 29211	1-800-856-9954
http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/			
South Dakota	Ryan White Program	615 E. 4th St Pierre SD 57501	1-800-592-1861
http://doh.sd.gov/diseases/infectious/ryanwhite/			
Tennessee	Ryan White Program	425 5th Ave N. 3rd Fl Nashville TN 37243	1-800- 525-2437
http://www.tn.gov/health/topic/STD-ryanwhite			
Texas	Texas HIV Medication Program	PO Box 149347 MC 1873 Austin TX 78714	1-800-255-1090
https://www.dshs.texas.gov/hivstd/meds/document.shtm			

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Utah http://health.utah.gov/epi/treatment/	Utah ADAP	PO Box 142104 Salt Lake City UT 84114-2104	1-801-538-6197
Vermont http://healthvermont.gov/prevent/aids/aids_index.aspx	VT Medication Assistance Program	108 Cherry St Burlington VT 05402	1-802-863-7245
Virginia http://166.67.66.226/epidemiology/DiseasePrevention/Programs/ADAP/	Virginia ADAP	VA Dept of Health 109 Governor St, 1st Floor Richmond VA 23219	1-855-362-0658
Washington http://www.doh.wa.gov/portals/1/documents/pubs/430-025-EIPBrochure.pdf	Early Intervention Program	PO Box 47841 Olympia WA 98504-7841	1-877-376-9316
West Virginia http://www.dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx	WV ADAP	PO Box 6360 Wheeling WV 26003	1-304-232-6822
Wisconsin https://www.dhs.wisconsin.gov/aids-hiv/adap.htm	WI ADAP	PO Box 2659 Madison WI 53701-2659	1-800-991-5532
Wyoming https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/forms/	Communicable Disease Services Program	401 Hathaway Building Cheyenne WY 82002	1-307-777-7529

Navitus MedicareRx Customer Care

Method	Customer Care – Contact Information
CALL	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. Pharmacies can also reach Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. Customer Care also has free language interpreter services available for non-English speakers.
WRITE	Navitus MedicareRx (PDP) Customer Care P.O. Box 1039 Appleton, WI 54912-1039
WEBSITE	https://memberportal.navitus.com

SHIP (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. Refer to **Exhibit A** in this Evidence of Coverage.

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.*