Your Medicare prescription drug coverage as a Member of the Enhanced or Basic Medicare Rx Option (A stand-alone prescription drug plan with a Medicare contract. Enrollment in the Health Options Program prescription drug plan options depends on contract renewal.)

This booklet gives you the details about your Medicare prescription drug coverage from January 1 - December 31, 2019. It explains how to get coverage for the prescription drugs you need. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2020, or at any time. You will receive notice when necessary. This is an important legal document. Please keep it in a safe place.

Additional Resources

- The HOP Administration Unit has free language interpreter services available for non-English speakers.
- Contact the HOP Administration Unit for information about the availability of large print materials.

MEMBER SERVICES

For help or information about prescription drugs, please call OptumRx.

Phone: 1-888-239-1301 (Calls to this number are free)

TTY: 1-800-498-5428 (Calls to this number are free)

Hours: 24 hours/7 days a week

For help or information about enrollment, billing or ID cards, please call the HOP Administration Unit or go to our plan website at www.HOPbenefits.com.

Phone: 1-800-773-7725 (Calls to this number are free)

TTY: 1-800-498-5428 (Calls to this number are free)

Fax: 1-877-411-4921

Hours: Monday–Friday, 8 am – 8 pm

June 2019
About the Enhanced and Basic Medicare Rx Options

- The Enhanced and Basic Medicare Rx Options are stand-alone prescription drug plans with a Medicare contract.
- When this booklet says “we,” “us,” or “our,” it means the PSERS Health Options Program. When it says “plan” or “our plan,” it means the Enhanced or Basic Medicare Rx Option.

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INTRODUCTION

Section 1.1  You are enrolled in the Enhanced or Basic Medicare Rx Option, which are Medicare prescription drug plans

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

There are different types of Medicare plans. The Enhanced and Basic Medicare Rx Options are Medicare prescription drug plans (PDPs). Like all Medicare plans, these Medicare prescription drug plans are approved by Medicare.

Section 1.2  What is the Evidence of Coverage booklet about?

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

The words “coverage” and “covered drugs” refer to the prescription drug coverage available to you as a member of the Enhanced or Basic Medicare Rx Option.

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

If you are confused or concerned or just have a question, please contact OptumRx for information about prescription drugs or the HOP Administration Unit for information about enrollment, billing, or ID cards (contact information is on the cover of this booklet).

Section 1.3  Legal information about the Evidence of Coverage

It’s part of our contract with you

This Evidence of Coverage is part of our contract with you about how the Enhanced or Basic Medicare Rx Option 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 the Enhanced or Basic Medicare Rx Option between January 1, 2019 and December 31, 2019.

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 the Enhanced and Basic Medicare Rx Options after December 31, 2019. We can also choose to stop offering one or both plans, or to offer them in a different service area, after December 31, 2019.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve the Enhanced and Basic Medicare Rx Options each year. You can continue 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 or Medicare Part B (or you have both Part A and Part B) (Section 2.2 tells you about Medicare Part A and Medicare Part B), and
- You are a United States citizen or are lawfully present in the United States, and
- You live in our geographic service area (Section 2.3 describes our service area).

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

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

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

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

Section 2.3  Here is the plan service area for the Enhanced and Basic Medicare Rx Options

Although Medicare is a federal program, the Enhanced and Basic Medicare Rx Options are available only to individuals who are eligible to enroll in the Health Options Program and live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. Our service area includes all 50 states.

If you plan to move out of the service area, please contact the HOP Administration Unit (phone numbers are printed on the front cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4  U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify the Health Options Program if you are not eligible to remain a member on this basis. The Health Options Program must disenroll you if you do not meet this requirement.
### Section 3.1 Your plan membership card – Use it to get all covered prescription drugs

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:

![Sample Membership Card](image)

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 the HOP Administration Unit to ask us to mail you a new card. (Phone numbers for the HOP Administration Unit right away and we will send you a new card. (Phone numbers are printed on the front cover of this booklet).

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

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

What are “network pharmacies”? Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies? You can use the Pharmacy Directory to find the network pharmacy you want to use. We send you a list of network pharmacies closest to where you live. Complete Pharmacy Directories by state are located on our website at www.HOPBenefits.com. You may also call the HOP Administration Unit to ask us to mail you a Pharmacy Directory. Please review the 2019 Pharmacy Directory to see which pharmacies are in our network.

If you don’t have the Pharmacy Directory, you can get a copy from the HOP Administration Unit (phone numbers are printed on the back cover of this booklet). At any time, you can call OptumRx to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.HOPBenefits.com.

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

The plan has a List of Covered Drugs (Formulary). We call it the “Drug List” for short. It tells which Part D prescription drugs are covered by the Enhanced and Basic Medicare Rx Options. 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 Enhanced and Basic Medicare Rx Options Drug List.

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

We provide you a copy of the Abridged Prescription Drug Formulary. The Abridged Formulary for the Enhanced and Basic Medicare Rx Options includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Abridged Formulary for the Enhanced and Basic Medicare Rx Options. If one of your drugs is not listed in the Drug List, you should visit our website or contact the HOP Administration Unit 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 (www.HOPbenefits.com) or call the HOP Administration Unit (phone numbers are on the front cover of this booklet).

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

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

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

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

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. Chapter 2, Section 7 tells more about these programs. If you qualify for one of these programs, the information about premiums in this Evidence of Coverage may not apply to you. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call the HOP Administration Unit and ask for the “LIS Rider.” (Phone numbers for the HOP Administration Unit are printed on the front cover of this booklet).

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed in Section 4.1.
Some members are required to pay a Part D late enrollment penalty because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn’t have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan’s monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.

- If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or 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 added to your monthly premium. When you first enroll in the Enhanced or Basic Medicare Rx Option, we let you know the amount of the penalty. Your Part D late enrollment penalty is considered part of your plan premium. If you do not pay the part of your premium that is the Part D late enrollment penalty, you could be disenrolled for failure to pay your plan premium.

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

Medicare determines the amount of the penalty. Here is how it works:
- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn’t have creditable coverage. For our example, let’s say it is 14 months without coverage, which 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 2018, this average premium amount was $35.02. This amount may change for 2019.
- 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 $35.02, which equals $4.90. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

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

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

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:
- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. Medicare calls this “creditable drug coverage.”
- If you receive a “certificate of creditable coverage” from the plan.

Creditable drug coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
- Please note: If you receive a “certificate of creditable coverage” when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had “creditable” prescription drug coverage that expected to pay as much as Medicare’s standard prescription drug plan pays.
- The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, please look in your Medicare & You handbook or call Medicare.

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

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review within 60 days from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty. Call the HOP Administration Unit to find out more about how to do this (phone numbers are printed on the front cover of this booklet).
If you have to pay an extra amount, Social Security will send you a letter telling you what that extra amount will be.

For more information about Part D premiums based on income, go to Chapter 1, Section 1.4 of this booklet. You can also visit https://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of Medicare & You 2019 gives information about the Medicare premiums in the section called “2019 Medicare Costs.” This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of Medicare & You each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of Medicare & You 2019 from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Your income is $85,000 or above for an individual (or married couples), or $170,000 or above for married couples, you must pay an extra amount directly to the government (not your Medicare plan) for your Medicare Part D coverage.

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

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be.

For more information about Part D premiums based on income, go to Chapter 1, Section 1.4 of this booklet. You can also visit https://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

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

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-328-0778).

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

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

Section 7 MORE INFORMATION ABOUT YOUR MONTHLY PREMIUM

Section 7.1 Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. Some plan members (those who aren’t eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B.

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, or IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or $170,000 for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

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

Method 1: The plan premium is taken out of your monthly PSERS retirement benefit
If you can pay your entire premium (including your medical premium, if any) with your PSERS retirement benefit, it is deducted from your monthly PSERS retirement benefit.

Method 2: You pay by check
If you are in the Enhanced or Basic Medicare Rx Option on a standalone basis (without medical coverage) or you cannot pay your entire premium (including your medical premium) with your PSERS retirement benefit, you must pay your monthly plan premium directly to our plan. If you make direct payment, you will receive a coupon book prior to your coverage effective date. The monthly coupon and check must be mailed to Health Options Program, PO Box 64979, Baltimore, MD 21264-4979 by the 25th day of the prior month. If you run out of coupons or lose your coupon book, call the HOP Administration Unit.

Contact the HOP Administration Unit if you have any questions about your plan premiums.

What to do if you are having trouble paying your plan premium
If you pay by check, your plan premium is due in our office by the 25th day of the prior month. If we have not received your premium by the 25th day of the prior month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within 60 days.

If you are having trouble paying your premium on time, please contact the HOP Administration Unit to see if we can direct you to programs that will help with your plan premium. (Phone numbers for the HOP Administration Unit are printed on the front cover of this booklet.)
If we end your membership with the plan because you did not pay your premiums, and you don’t currently have prescription drug coverage, then you will not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual Medicare open enrollment period. At that time, you may either join a standalone prescription drug plan or a health plan that also provides drug coverage. (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 we end your membership because you did not pay your premiums, you will still have coverage under Original Medicare. At the time we end your membership, you may still owe us premiums for premiums you have not paid. In the future, you can enroll again in our plan (or another plan that we offer) only if you experience a Qualifying Event and pay these late premiums.

If you think we have wrongfully ended your membership, you can reconsider this decision by making 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 premiums during the year, you will need to start paying their full monthly premium. You can find out more about the “Extra Help” program in Chapter 2, Section 7.

SECTION 8 PLEASE KEEP YOUR PLAN MEMBERSHIP RECORD UP TO DATE

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

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

If any of this information changes, please let us know by calling the HOP Administration Unit (phone numbers are printed on the front cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

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

That’s because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other 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 the HOP Administration Unit (phone numbers are on the cover of this booklet).

SECTION 9 WE PROTECT THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

Section 9.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 10 HOW OTHER INSURANCE WORKS WITH OUR PLAN

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

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer 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 plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you’re over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.
These types of coverage usually pay first for services related to each type:

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call the HOP Administration Unit (phone numbers are on the front cover of this booklet). 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.
SECTION 1
CONTACTS FOR THE ENHANCED AND BASIC MEDICARE RX OPTIONS (HOW TO CONTACT US, INCLUDING HOW TO REACH THE HOP ADMINISTRATION UNIT)

How to contact the HOP Administration Unit
For assistance with enrollment, billing or member card questions, please call or write to the HOP Administration Unit. We will be happy to help you.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>HOPE ADMINISTRATION UNIT—CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-773-7725 (Calls to this number are free.) 8 am – 8 pm ET, Monday through Friday</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-498-5428. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. (Calls to this number are free.) 8 am - 8 pm ET, Monday through Friday</td>
</tr>
<tr>
<td>FAX</td>
<td>1-877-411-4921</td>
</tr>
<tr>
<td>WRITE</td>
<td>HOP Administration Unit, P.O. Box 1764, Lancaster, PA 17608-1764</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.HOPbenefits.com">www.HOPbenefits.com</a></td>
</tr>
</tbody>
</table>

How to contact us when you are asking for a coverage decision, or making an appeal and/or complaint about your Part D prescription drugs
You may call OptumRx with questions about our coverage decision process, appeals and/or complaints. 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. An appeal is a formal way of asking us to review and change a coverage decision we have made. 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 asking for coverage decisions, appeals and complaints about your Part D prescription drugs, see Chapter 7, entitled What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

<table>
<thead>
<tr>
<th>METHOD</th>
<th>COVERAGE DECISIONS, APPEALS AND COMPLAINTS FOR PART D PRESCRIPTION DRUGS—CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-888-239-1301 (Calls to this number are free.) 24 hours/7 days a week. Physicians can call 1-800-711-4555 for a standard or expedited coverage determination 24 hours/7 days a week</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-498-5428. 24 hours/7 days a week. This number requires special telephone equipment. (Calls to this number are free.)</td>
</tr>
<tr>
<td>FAX</td>
<td>1-877-239-4566. Physicians can fax 1-800-527-0531 for a standard or expedited coverage determination</td>
</tr>
<tr>
<td>WRITE</td>
<td>Coverage determinations and appeals: OptumRx, Attn: Part D Appeals Dept, Mail Stop CA106-0286, 3515 Harbor Boulevard, Costa Mesa, CA 92626</td>
</tr>
<tr>
<td></td>
<td>Complaints and grievances: OptumRx, Attn: Part D Grievances Dept, PO Box 3410, Lisle, IL 60532</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.optumrx.com">www.optumrx.com</a></td>
</tr>
</tbody>
</table>

MEDICARE WEBSITE: You can submit a complaint about the Enhanced or Basic Medicare Rx Option directly to Medicare. To submit an online complaint to Medicare go to https://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 that ask us to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (Asking us to pay our share of the costs for covered drugs).

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

<table>
<thead>
<tr>
<th>METHOD</th>
<th>PAYMENT REQUESTS—CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-888-239-1301 (Calls to this number are free.) 24 hours/7 days a week</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-498-5428. This number requires special telephone equipment. (Calls to this number are free.) 24 hours/7 days a week</td>
</tr>
<tr>
<td>WRITE</td>
<td>OptumRx P.O. Box 29046 Hot Springs, AR 71903</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.optumrx.com">www.optumrx.com</a></td>
</tr>
</tbody>
</table>
## 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**<br>1-800-MEDICARE or 1-800-633-4227 (Calls to this number are free.) 24 hours a day, 7 days a week.<br>Toll Free: (800) 994-9422<br>TTY users should call 1-877-486-2048. |<br>**WEBSITE**

https://www.medicare.gov<br>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool**: Provides Medicare eligibility status information.
- **Medicare Plan Finder**: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about the Enhanced or Basic Medicare Rx Option:

- **Tell Medicare about your complaint**: You can submit a complaint about the Enhanced or Basic Medicare Rx Option directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

### SECTION 3
### STATE HEALTH INSURANCE ASSISTANCE PROGRAM (FREE HELP, INFORMATION, AND ANSWERS TO YOUR QUESTIONS ABOUT MEDICARE)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. It is independent (not connected with any insurance company or health plan). SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors in your state can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills.

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

### PROGRAM | CALL | WRITE | WEBSITE
--- | --- | --- | ---
<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>CALL</th>
<th>WRITE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GeorgiaCares</td>
<td>Toll Free: (888) 552-4464 Local: (404) 657-5258</td>
<td>2 Peachtree St NW, 33rd Fl Atlanta, GA 30303</td>
<td><a href="http://www.mygeorgiacares.org">http://www.mygeorgiacares.org</a></td>
</tr>
<tr>
<td>Guam Medicare Assistance Program (GUAM MAP)</td>
<td>Local: (671) 735-7421 TTY: (671) 735-7415</td>
<td>Dept of Public Health and Social Services 123 Chalan Karetia, Mangilao, Guam 96913</td>
<td><a href="http://www.dphs.guam.gov/">http://www.dphs.guam.gov/</a></td>
</tr>
<tr>
<td>Hawaii State Health Insurance Assistance Program (SHIP)</td>
<td>Toll Free: (888) 875-9229 TTY: 1-866-810-4379 Local: (808) 968-7299</td>
<td>250 South Hotel Street, Suite 406 Honolulu, Hawaii 96813</td>
<td><a href="http://www.hawaiiship.org/">http://www.hawaiiship.org/</a></td>
</tr>
<tr>
<td>Idaho Senior Health Insurance Benefits Advisors (SHIBA)</td>
<td>Toll Free: (800) 247-4422 Local: (800) 721-3272</td>
<td>Department of Insurance 70 West State St, 3rd Floor P.O. Box 87270 Boise, ID 83720</td>
<td><a href="http://www.doi.idaho.gov">http://www.doi.idaho.gov</a></td>
</tr>
<tr>
<td>Illinois Senior Health Insurance Program (SHIP)</td>
<td>Toll Free: (800) 252-8966 TTY: (888) 206-1327</td>
<td>One Natural Resources Way, Suite 100 Springfield, IL 62702</td>
<td><a href="https://www.illinois.gov/aging/ship/Pages/default.aspx">https://www.illinois.gov/aging/ship/Pages/default.aspx</a></td>
</tr>
<tr>
<td>Indiana State Health Insurance Assistance Program (SHIP)</td>
<td>Toll Free: (800) 452-4800 TTY: (888) 846-0139</td>
<td>311 W. Washington Street, Ste 300 Indianapolis, IN 46204</td>
<td><a href="http://www.medicare.in.gov">http://www.medicare.in.gov</a></td>
</tr>
<tr>
<td>Iowa Senior Health Insurance Information Program (SHIP)</td>
<td>Toll Free: (800) 351-4664 TTY: (800) 735-2942</td>
<td>601 Locust St., 4th Floor Des Moines, IA 50309</td>
<td><a href="http://www.ship.state.ia.us/">http://www.ship.state.ia.us/</a></td>
</tr>
<tr>
<td>Kentucky State Health Insurance Program (SHIP)</td>
<td>Toll Free: (877) 293-7447 Local: (502) 564-6930</td>
<td>275 E. Main St Frankfort, KY 40621</td>
<td><a href="https://chfs.ky.gov/agencies/dail/Pages/ship.aspx">https://chfs.ky.gov/agencies/dail/Pages/ship.aspx</a></td>
</tr>
<tr>
<td>Louisiana Senior Health Insurance Information Program (SHIP)</td>
<td>Toll Free: (800) 258-5300 Local: (225) 342-5301</td>
<td>1702 N. Third St Baton Rouge, LA 70802</td>
<td><a href="http://www.lidi.la.gov/SHIP">http://www.lidi.la.gov/SHIP</a></td>
</tr>
<tr>
<td>Maine State Health Insurance Assistance Program (SHIP)</td>
<td>Toll Free: (800) 262-2232 Local: (887) 353-3771</td>
<td>41 Anthony Avenue Augusta, ME 04333</td>
<td><a href="http://www.maine.gov/dhhs/oads/community-support/ship.html">http://www.maine.gov/dhhs/oads/community-support/ship.html</a></td>
</tr>
</tbody>
</table>

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<tr>
<th>PROGRAM</th>
<th>CALL</th>
<th>WRITE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland State Health Insurance Assistance Program (SHIP)</td>
<td>Toll Free: (800) 243-3425 Local: (410) 767-1100</td>
<td>301 West Preston St, Suite 1007 Baltimore, MD 21201</td>
<td><a href="http://www.mdoa.state.md.us">http://www.mdoa.state.md.us</a></td>
</tr>
<tr>
<td>Massachusetts Serving Health Information Needs of Everyone (SHIP)</td>
<td>Toll Free: (800) 243-4636 Local: (617) 727-7750 TTY: (800) 439-2370</td>
<td>One Ashburnton Place, Room 517 Boston, MA 02108</td>
<td><a href="http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html">http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html</a></td>
</tr>
<tr>
<td>Minnesota State Health Insurance Assistance Program/Senior LinkAge Line</td>
<td>Toll Free: (800) 333-2433 Local: (651) 431-2500 TTY: (800) 827-3529</td>
<td>540 Cedar Street St Paul, MN 55105</td>
<td><a href="http://www.mnaging.org/">http://www.mnaging.org/</a></td>
</tr>
<tr>
<td>Mississippi State Health Insurance Assistance Program (SHIP)</td>
<td>Toll Free: (788) 777-7336</td>
<td>750 North State St Jackson, MS 34202</td>
<td><a href="http://www.mhhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/">http://www.mhhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/</a></td>
</tr>
<tr>
<td>Missouri CLAIM</td>
<td>Toll Free: (800) 398-3330 Local: (517) 817-8520</td>
<td>200 N. Keene St, Ste. 101 Columbia, MO 65201</td>
<td><a href="http://www.missouriclaim.org">http://www.missouriclaim.org</a></td>
</tr>
<tr>
<td>Nebraska Senior Health Insurance Program (SHIP)</td>
<td>Toll Free: (800) 234-7119 Local: (402) 471-2201</td>
<td>NE Dept of Insurance 941 0 St, Suite 400 Lincoln, NE 68508</td>
<td><a href="http://www.doi.ne.gov/ship">http://www.doi.ne.gov/ship</a></td>
</tr>
<tr>
<td>Nevada State Health Insurance Assistance Program (SHIP)</td>
<td>Toll Free: (800) 307-4444 Local: (775) 887-4210</td>
<td>3416 Goni Rd, Suite D-132 Carson City, NV 89706</td>
<td><a href="http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/">http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/</a></td>
</tr>
<tr>
<td>New Hampshire ServiceLink</td>
<td>Toll Free: (888) 634-9412</td>
<td>New Hampshire Department of Health and Human Services 129 Pleasant St Concord, NH 03301</td>
<td><a href="http://www.serviceNH.nh.gov">http://www.serviceNH.nh.gov</a></td>
</tr>
<tr>
<td>New Jersey State Health Insurance Assistance Program (SHIP)</td>
<td>Toll Free: (800) 792-8820</td>
<td>240 W State St Trenton, NJ 08690</td>
<td><a href="http://www.state.nj.us/humanservices/doas/services/ship/">http://www.state.nj.us/humanservices/doas/services/ship/</a></td>
</tr>
</tbody>
</table>
## Chapter 2: Important phone numbers and resources

### 2019 Evidence of Coverage January 1 - December 31, 2019

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>CALL</th>
<th>WRITE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tennessee SHIP</td>
<td>Toll Free: (877) 801-0044</td>
<td>502 Deaderick Street, 8th Floor Nashville, TN 37243</td>
<td><a href="http://tnmedicarehelp.com/?page_id=99">http://tnmedicarehelp.com/?page_id=99</a></td>
</tr>
<tr>
<td>Texas Health Information Counseling and Advocacy Program (HICAP)</td>
<td>Toll Free: (800) 252-9240</td>
<td>P.O. Box 149030 Austin, TX 78714-9030</td>
<td><a href="https://ths.tx.gov/services/health/medicare">https://ths.tx.gov/services/health/medicare</a></td>
</tr>
<tr>
<td>Utah Senior Health Insurance Information Program (SHIP)</td>
<td>Toll Free: (800) 541-7735</td>
<td>195 North 1950 West Salt Lake City, Utah 84116</td>
<td><a href="https://daas.utah.gov/">https://daas.utah.gov/</a></td>
</tr>
<tr>
<td>Vermont State Health Insurance Assistance Program (SHIP)</td>
<td>Toll Free: (877) 379-2600 Local: (802) 479-0531</td>
<td>59 N. Main Street, Suite 200 Barre, VT 05641</td>
<td><a href="https://www.vt.gov/health-insurance-counseling.html">https://www.vt.gov/health-insurance-counseling.html</a></td>
</tr>
<tr>
<td>Virgin Islands State Health Insurance Assistance Program (VSHIP)</td>
<td>Local: (340) 772-7368</td>
<td>4700 Estate Diamond, 1st Fl St Croix, VI 00820</td>
<td><a href="http://tfgov.vi/vi-ship-medicare.html">http://tfgov.vi/vi-ship-medicare.html</a></td>
</tr>
<tr>
<td>Virginia Insurance Counseling and Assistance Program (VICA)</td>
<td>Toll Free: (800) 552-3402 Local: (804) 862-9333</td>
<td>1610 Forest Avenue, Suite 100 Henrico, VA 23229</td>
<td><a href="http://www.vda.virginia.gov">http://www.vda.virginia.gov</a></td>
</tr>
<tr>
<td>West Virginia State Health Insurance Assistance Program (WV SHIP)</td>
<td>Toll Free: (877) 987-4463 Local: (304) 358-3177</td>
<td>1900 Kanawha Blvd East Charleston, WV 25305</td>
<td><a href="http://www.wvship.org">http://www.wvship.org</a></td>
</tr>
<tr>
<td>Wyoming State Health Insurance Information Program (WSHIP)</td>
<td>Toll Free: (800) 856-4398 Local: (800) 856-4398</td>
<td>106 West Adams Avenue Riverton, WY 82501</td>
<td><a href="http://www.wyoming">http://www.wyoming</a> seniors.com/services/wyoming-state-health-insurance-information-program</td>
</tr>
</tbody>
</table>

### Important phone numbers and resources

#### South Dakota

**Senior Health Information & Insurance Education (SHINE)**
- **CALL**: (605) 536-8197
- **WRITE**: 2300 W 48th St. Sioux Falls, SD 57105
- **WEBSITE**: http://www.shine.net

**North Dakota Senior Health Insurance Counseling (SHIC)**
- **CALL**: (888) 575-8611
- **WRITE**: 600 E Boulevard Ave Bismarck, ND 58505
- **WEBSITE**: http://www.state.nd.us/ndins/

**Ohio Senior Health Insurance Information Program (OSHIP)**
- **CALL**: (800) 686-1578
- **WRITE**: 50 W. Town St, Suite 300 Columbus, OH 43215
- **WEBSITE**: http://www.insurance.ohio.gov/aboutodi/odidiv/pages/ship.aspx

**Oklahoma Senior Health Insurance Counseling Program (OSHIP)**
- **CALL**: (405) 521-6628
- **WRITE**: Five Corporate Plaza 3625 NW 56th, Suite 100 Oklahoma City, OK 73112
- **WEBSITE**: https://www.ok.gov/oid/consumers/Information_for_Seniors/SHIP.html

**Oregon Senior Health Insurance Benefits Assistance (SHIBA)**
- **CALL**: (800) 722-4134
- **WRITE**: P.O. Box 14480 Salem, OR 97309
- **WEBSITE**: http://www.oregon.gov/dhs/shba/Pages/index.aspx

**Pennsylvania APPRISE**
- **CALL**: (800) 783-7057
- **WRITE**: 555 Walnut St, 5th Fl Harrisburg, PA 17101
- **WEBSITE**: http://aging.state.pa.us

**Puerto Rico State Health Insurance Assistance Program (SHIP)**
- **CALL**: (637) 725-4300 Local: (787) 721-6121 TTY: (787) 719-7291
- **WRITE**: P.O. Box 19179 P.O. Box 40255 P.O. Box 40255
- **WEBSITE**: http://aging.pr.gov/benefit_specialists/medicare-counseling.html

**Rhode Island Senior Health Insurance Program (SHIP)**
- **CALL**: (401) 462-4444 Local: (401) 462-4445
- **WRITE**: 50 Valley Street Providence, RI 02909
- **WEBSITE**: http://www.dea.ri.gov/insurance/

**South Carolina (S-CARE) Insurance Counseling Assistance and Referrals for Elders**
- **CALL**: (803) 734-9900
- **WRITE**: 1301 Gervais St, Suite 350 Columbia, SC 29201
- **WEBSITE**: http://aging.sc.gov/

**South Dakota Senior Health Information & Insurance Education (SHINE)**
- **CALL**: (605) 333-3314
- **WRITE**: 2300 W 48th St. Sioux Falls, SD 57105
- **WEBSITE**: http://www.shine.net

**New Mexico Benefits Counseling Program**
- **CALL**: (800) 432-2080 Local: (505) 476-4846 TTY: (505) 476-4937
- **WRITE**: P.O. Box 27118 Santa Fe, NM 87502
- **WEBSITE**: http://www.nmaging.state.nm.us

**New York Health Insurance Information Counseling and Assistance Program (HIICAP)**
- **CALL**: (800) 701-0501
- **WRITE**: Office for the Aging 2 Empire State Plaza Albany, New York 12223
- **WEBSITE**: https://www.nyaging.ny.gov/HealthBenefits/Index.cfm

**North Carolina Senior Health Insurance Counseling Program (CHICAP)**
- **CALL**: (888) 507-1212
- **WRITE**: 1201 Mail Service Center Raleigh, NC 27699
- **WEBSITE**: http://www.ncdoi.com/ship/

**North Dakota Senior Health Insurance Counseling (SHIC)**
- **CALL**: (800) 541-7735
- **WRITE**: 195 North 1950 West Salt Lake City, Utah 84116
- **WEBSITE**: https://daas.utah.gov/
## SECTION 4

**BENEFICIARY AND FAMILY-CENTERED CARE QUALITY IMPROVEMENT ORGANIZATIONS (PAID BY MEDICARE TO CHECK ON THE QUALITY OF CARE FOR PEOPLE WITH MEDICARE)**

There are two Beneficiary and Family-Centered Care Quality Improvement Organizations that serve ten areas. These organizations are paid by Medicare to check on and help improve the quality of care for people with Medicare. They are independent organizations. They are not connected with our plan.

You should contact the Beneficiary and Family-Centered Care Quality Improvement Organization that serves your state if you have a complaint about the quality of care you have received. For example, you can contact the Beneficiary and Family-Centered Care Quality Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

<table>
<thead>
<tr>
<th>AREA</th>
<th>ADDRESS</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Connecticut&lt;br&gt; Maine&lt;br&gt; Massachusetts&lt;br&gt; New Hampshire&lt;br&gt; Rhode Island&lt;br&gt; Vermont</td>
<td>KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131</td>
</tr>
<tr>
<td>2</td>
<td>New Jersey&lt;br&gt; New York&lt;br&gt; Puerto Rico&lt;br&gt; Virgin Islands</td>
<td>Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701</td>
</tr>
<tr>
<td>3</td>
<td>Delaware&lt;br&gt; District of Columbia&lt;br&gt; Maryland&lt;br&gt; Pennsylvania&lt;br&gt; Virginia&lt;br&gt; West Virginia</td>
<td>Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701</td>
</tr>
<tr>
<td>4</td>
<td>Alabama&lt;br&gt; Florida&lt;br&gt; Georgia&lt;br&gt; Kentucky&lt;br&gt; Mississippi&lt;br&gt; North Carolina&lt;br&gt; South Carolina&lt;br&gt; Tennessee</td>
<td>KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609</td>
</tr>
<tr>
<td>5</td>
<td>Illinois&lt;br&gt; Indiana&lt;br&gt; Michigan&lt;br&gt; Minnesota&lt;br&gt; Ohio&lt;br&gt; Wisconsin</td>
<td>Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701</td>
</tr>
<tr>
<td>6</td>
<td>Arkansas&lt;br&gt; Louisiana&lt;br&gt; New Mexico&lt;br&gt; Oklahoma&lt;br&gt; Texas</td>
<td>KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609</td>
</tr>
<tr>
<td>7</td>
<td>Iowa&lt;br&gt; Kansas&lt;br&gt; Missouri&lt;br&gt; Nebraska</td>
<td>Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701</td>
</tr>
<tr>
<td>8</td>
<td>Colorado&lt;br&gt; Montana&lt;br&gt; North Dakota&lt;br&gt; South Dakota&lt;br&gt; Utah&lt;br&gt; Wyoming</td>
<td>KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131</td>
</tr>
<tr>
<td>9</td>
<td>Arizona&lt;br&gt; California&lt;br&gt; Hawaii&lt;br&gt; Nevada&lt;br&gt; Pacific Islands</td>
<td>Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701</td>
</tr>
<tr>
<td>10</td>
<td>Alaska&lt;br&gt; Idaho&lt;br&gt; Oregon&lt;br&gt; Washington</td>
<td>KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131</td>
</tr>
</tbody>
</table>
SECTION 5
SOCIAL SECURITY

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration. If you move or change your mailing address, it is important that you contact Social Security to let them know.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>SOCIAL SECURITY—CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-772-1213. (Calls to this number are free.) Available 7:00 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.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-325-0778. (Calls to this number are free.) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Available 7:00 am to 7:00 pm ET, Monday through Friday.</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="https://www.ssa.gov/">https://www.ssa.gov/</a></td>
</tr>
</tbody>
</table>

SECTION 6
MEDIACARE (A JOINT FEDERAL AND STATE PROGRAM THAT HELPS WITH MEDICAL COSTS FOR SOME PEOPLE WITH LIMITED INCOME AND RESOURCES)

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

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

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

To find out more about Medicaid and its programs, contact the Medicaid office in your state.

<table>
<thead>
<tr>
<th>STATE</th>
<th>CALL</th>
<th>WRITE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1-800-362-1504, 1-334-242-5000</td>
<td>P.O. Box 5624 Montgomery, AL 36103</td>
<td><a href="http://www.medicaid.alabama.gov/">http://www.medicaid.alabama.gov/</a></td>
</tr>
<tr>
<td>Alaska</td>
<td>1-800-780-9972, 1-907-465-3347</td>
<td>P.O. Box 110635 Juneau, AK 99811</td>
<td><a href="http://www.hss.state.ak.us/dpa/programs/medicaid/">http://www.hss.state.ak.us/dpa/programs/medicaid/</a></td>
</tr>
<tr>
<td>Arkansas</td>
<td>1-800-482-5431, 1-501-682-8501</td>
<td>P.O. Box 1437, Slot 5401 Donaghey Plaza South Little Rock, AR 72203</td>
<td><a href="https://medicaid.mmis.arkansas.gov/">https://medicaid.mmis.arkansas.gov/</a></td>
</tr>
<tr>
<td>California</td>
<td>1-916-445-4171, 1-916-445-0553 (TTY)</td>
<td>P.O. Box 989725 West Sacramento, CA 95798</td>
<td><a href="https://benefits.gov/benefits/benefit-details/1620">https://benefits.gov/benefits/benefit-details/1620</a></td>
</tr>
<tr>
<td>Colorado</td>
<td>1-800-221-3943, 1-303-866-2893</td>
<td>1570 Grant St. Denver, CO 80203</td>
<td><a href="http://www.chcpf.state.co.us">http://www.chcpf.state.co.us</a></td>
</tr>
<tr>
<td>District of Columbia</td>
<td>1-855-532-5465, 1-855-532-5465 (TTY)</td>
<td>P.O. Box 91560 Washington, DC 20090</td>
<td><a href="https://dchealthlink.com/individuals/medicaid">https://dchealthlink.com/individuals/medicaid</a></td>
</tr>
<tr>
<td>Florida</td>
<td>1-888-725-1055, 1-888-766-2237, 1-800-955-8171 (TTY)</td>
<td>P.O. Box 7054 Tallahassee, FL 32314</td>
<td><a href="http://www.flhce.state.fl.us/">www.flhce.state.fl.us/</a></td>
</tr>
<tr>
<td>Georgia</td>
<td>1-888-552-4464, 1-877-423-4746</td>
<td>2 Peachtree St., NW Atlanta, GA 30303</td>
<td><a href="http://www.dch.georgia.gov">www.dch.georgia.gov</a></td>
</tr>
<tr>
<td>Hawaii</td>
<td>1-808-586-5390</td>
<td>P.O. Box 70190 Kapolei, Hawaii 96709</td>
<td><a href="https://medquest.hawaii.gov/">https://medquest.hawaii.gov/</a></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>STATE</th>
<th>CALL</th>
<th>WRITE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>1-800-403-0864</td>
<td>P. O. Box 1810, Merion, ID 48952</td>
<td><a href="http://member.indianahealthplan.com/">http://member.indianahealthplan.com/</a></td>
</tr>
<tr>
<td>Iowa</td>
<td>1-800-338-8366</td>
<td>100 Army Post Road Des Moines, IA 50315</td>
<td><a href="http://dhs.iowa.gov/iahealthlink">http://dhs.iowa.gov/iahealthlink</a></td>
</tr>
<tr>
<td>Kansas</td>
<td>1-800-792-4884</td>
<td>P. O. Box 3598, Topeka, KS 66601</td>
<td>[<a href="http://www.kancare">http://www.kancare</a> ks.gov/](<a href="http://www.kancare">http://www.kancare</a> ks.gov/)</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1-800-635-2570</td>
<td>275 E. Main St. Frankfort, KY 40621</td>
<td><a href="http://www.chfs.ky.gov">www.chfs.ky.gov</a></td>
</tr>
<tr>
<td>Maryland</td>
<td>1-855-642-8572</td>
<td>P. O. Box 17259, Baltimore, MD 21203-1759</td>
<td><a href="http://www.dhhs.oms/">www.dhhs.oms/</a></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1-800-841-2800</td>
<td>One Ashburn Place, 11th Floor Boston, MA 02108</td>
<td><a href="http://www.mass.gov/masshealth">www.mass.gov/masshealth</a></td>
</tr>
<tr>
<td>Michigan</td>
<td>1-800-642-3195</td>
<td>333 S. Grand Ave. P. O. Box 30195, Lansing, MI 48909</td>
<td><a href="http://www.michigan.gov/mdch">www.michigan.gov/mdch</a></td>
</tr>
<tr>
<td>Mississippi</td>
<td>1-800-421-2408</td>
<td>550 High St., Suite 1000 Jackson, MS 39201</td>
<td><a href="http://medicaid.ms.gov">medicaid.ms.gov</a></td>
</tr>
<tr>
<td>Missouri</td>
<td>1-800-348-6267</td>
<td>615 Howerton Court P. O. Box 6500 Jefferson City, MO 65102-1527</td>
<td><a href="https://mydss.mo.gov/healthcare">https://mydss.mo.gov/healthcare</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Call</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montana</td>
<td>1-800-382-8312</td>
<td>1400 Broadway Helena, MT 59604-8005 <a href="http://www.dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices">http://www.dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices</a></td>
</tr>
<tr>
<td>Nebraska</td>
<td>1-800-358-8802</td>
<td>301 Centennial Mall South Lincoln, Nebraska 68509 <a href="http://dhs.ne.gov/medical/Pages/med_medindex.aspx">http://dhs.ne.gov/medical/Pages/med_medindex.aspx</a></td>
</tr>
<tr>
<td>Nevada</td>
<td>1-877-638-3472</td>
<td>P. O. Box 30042 Reno, NV 89520 <a href="http://www.medicaid.nv.gov/">http://www.medicaid.nv.gov/</a></td>
</tr>
<tr>
<td>New Jersey</td>
<td>1-800-356-1561</td>
<td>P. O. Box 712 Trenton, NJ 08625 <a href="http://www.state.nj.us/">www.state.nj.us/</a></td>
</tr>
<tr>
<td>New Mexico</td>
<td>1-888-997-2583</td>
<td>P. O. Box 2348 Santa Fe, NM 87504 <a href="http://www.hsd.state.nm.us">http://www.hsd.state.nm.us</a></td>
</tr>
<tr>
<td>New York</td>
<td>1-800-541-2831</td>
<td>New York State Department of Health <a href="http://www.health.state.ny.us">http://www.health.state.ny.us</a></td>
</tr>
<tr>
<td>North Carolina</td>
<td>1-800-662-7030</td>
<td>1985 Umstead Dr. Raleigh, NC 27603 <a href="https://dma.ncdhhs.gov/medicaid">https://dma.ncdhhs.gov/medicaid</a></td>
</tr>
<tr>
<td>Ohio</td>
<td>1-800-324-8680</td>
<td>50 West Town Street, Suite 400 Columbus, Ohio 43215 <a href="http://www.ohio.gov/ohp">http://www.ohio.gov/ohp</a></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1-800-987-7767</td>
<td>Oklahoma Health Care Authority 3435 N. Lincoln Blvd. Oklahoma City, OK 73105 <a href="http://www.okhca.org">www.okhca.org</a></td>
</tr>
</tbody>
</table>
## SECTION 7: INFORMATION ABOUT PROGRAMS TO HELP PEOPLE PAY FOR THEIR PRESCRIPTION DRUGS

### Medicare’s “Extra Help” Program

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

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

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

<table>
<thead>
<tr>
<th>STATE</th>
<th>CALL</th>
<th>WRITE</th>
<th>WEBSITE</th>
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</thead>
<tbody>
<tr>
<td>Wisconsin</td>
<td>1-800-362-3002</td>
<td>P.O. Box 5234</td>
<td><a href="https://www.dhs.wisconsin.gov/medicaid/index.htm">https://www.dhs.wisconsin.gov/medicaid/index.htm</a></td>
</tr>
</tbody>
</table>

### Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D members who have reached the coverage gap and are not receiving “Extra Help.”

- **The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday.** If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D

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**2019 Evidence of Coverage January 1 - December 31, 2019**

Chapter 2: Important phone numbers and resources

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**2019 Evidence of Coverage for the Enhanced and Basic Medicare Rx Options**

Chapter 2: Important phone numbers and resources

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Pennsylvania, the program is called the AIDS Drug Assistance Program (ADAP). In Pennsylvania, the program is called the Special Pharmaceutical Benefits Program (SPBP).

**Pharmaceutical Benefits Program (SPBP).**

Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status through low income as defined by the state, and uninsured/under-insured status.

If you are currently enrolled in the SPBP or another ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary.

In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information on eligibility criteria, covered drugs, or how to enroll in the SPBP, please call 1-800-922-9384 or send an email to SPBP@health.state.pa.us. If you need help contacting an ADAP outside of Pennsylvania, call the HOP Administration Unit. (Phone numbers for the HOP Administration Unit are printed on the front cover of this booklet.)

**What if you get “Extra Help” from Medicare to help pay your prescription drug costs?**

Can you get the discounts?

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

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

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next Part D Explanation of Benefits (Part D EOB) notice. If the discount doesn’t appear on your Part D Explanation of Benefits, you should contact us to make sure that your prescription records are correct and up to date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-803-3627.

**State Pharmaceutical Assistance Programs**

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

Here is a list of the State Pharmaceutical Assistance Programs.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>CALL</th>
<th>WRITE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado Bridging the Gap</td>
<td>(303) 892-2716</td>
<td>4300 Cherry Creek South Drive Denver, CO 80246</td>
<td><a href="https://www.colorado.gov/pacific/dphe/colorado-aids-drug-assistance-program-adap">https://www.colorado.gov/pacific/dphe/colorado-aids-drug-assistance-program-adap</a></td>
</tr>
<tr>
<td>Delaware Prescription Assistance Program (PDAP)</td>
<td>(800) 996-9989</td>
<td>P.O. Box 950 New Castle, DE 19972</td>
<td><a href="http://www.dhss.delaware.gov/dhss/dmma/dpap.html#print">http://www.dhss.delaware.gov/dhss/dmma/dpap.html#print</a></td>
</tr>
<tr>
<td>Idaho AIDS Drug Assistance Program (IDAGAP)</td>
<td>(208) 334-5612</td>
<td>450 W. State Street P.O. Box 83720 Boise, ID 83720</td>
<td><a href="http://healthandwelfare.idaho.gov/Health/FamilyPlanning/STDHIV/HIVCareandTreatment/tabid/391/Default.aspx">http://healthandwelfare.idaho.gov/Health/FamilyPlanning/STDHIV/HIVCareandTreatment/tabid/391/Default.aspx</a></td>
</tr>
<tr>
<td>HoosierRx</td>
<td>(866) 267-4679</td>
<td>P.O. Box 6224 Indianapolis, IN 46206</td>
<td><a href="http://www.in.gov/ffsa/elderly/hoosierrx/">http://www.in.gov/ffsa/elderly/hoosierrx/</a></td>
</tr>
<tr>
<td>Maine Drugs for the Elderly or Disabled Program</td>
<td>(866) 796-2463</td>
<td>Office of MaineCare Services 11 State House Station Augusta, Maine 04333</td>
<td><a href="http://www.maine.gov/dhhs/oms/">http://www.maine.gov/dhhs/oms/</a></td>
</tr>
<tr>
<td>Maryland Senior Prescription Drug Assistance Program</td>
<td>(800) 551-5995</td>
<td>SPDAP c/o Pool Administrators 628 Hebron Ave, Suite 100 Glastonbury, CT 06033</td>
<td><a href="http://marylandspdap.com">http://marylandspdap.com</a></td>
</tr>
<tr>
<td>Massachusetts Prescription Advantage</td>
<td>(800) 243-4636</td>
<td>One Ashburton Place, Room 517 Boston, MA 02110</td>
<td><a href="http://www.mass.gov/elders/healthcare/prescription-advantage/">http://www.mass.gov/elders/healthcare/prescription-advantage/</a></td>
</tr>
<tr>
<td>Missouri Rx Plan</td>
<td>(800) 375-1406</td>
<td>P.O. Box 6500 Jefferson City, MO 65102</td>
<td><a href="http://morx.mo.gov">http://morx.mo.gov</a></td>
</tr>
<tr>
<td>Montana Big Sky Rx Program</td>
<td>(866) 369-1233</td>
<td>P.O. Box 222915 Helena, MT 59620</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx">http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx</a></td>
</tr>
<tr>
<td>Nevada Senior Rx Program</td>
<td>(775) 867-4210</td>
<td>3416 Goni Road, Suite D-132 Carson City, NV 89706</td>
<td><a href="http://adsl.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/">http://adsl.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/</a></td>
</tr>
</tbody>
</table>
### Section 8: How to Contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

#### Method

<table>
<thead>
<tr>
<th>RAILROAD RETIREMENT BOARD—CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALL</strong></td>
</tr>
<tr>
<td>1-877-772-5772. (Calls to this number are free.) Available 9:00 am to 3:30 pm, Monday through Friday.</td>
</tr>
<tr>
<td>1-312-751-4701. (Calls to this number are free.) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
</tbody>
</table>

**WEBSITE**

https://secure.rrb.gov/
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Did you know there are programs to help people pay for their drugs?

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

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”) that tells you about your drug coverage. If you don’t have this insert, please call the HOP Administration Unit and ask for the “LIS Rider.” (Phone numbers for the HOP Administration Unit are on the front cover of this booklet.)

SECTION 1
INTRODUCTION

Section 1.1 This chapter describes your coverage for Part D drugs

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

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

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

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your Medicare & You handbook.) Your Part D prescription drugs are covered under our plan.

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

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

■ You must have a provider (a doctor, dentist or other prescriber) write your prescription.

■ Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

■ You 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 service.)

■ Your drug must be on the plan’s List of Covered Drugs (Formulary). (We call it the “Drug List” for short.) (See Section 3, Your drugs need to be on the plan’s “Drug List.”)

■ Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2
FILL YOUR PRESCRIPTION AT A NETWORK PHARMACY OR THROUGH THE PLAN’S MAIL-ORDER SERVICE

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

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

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

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

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

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

If the pharmacy you have been using leaves the network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can log onto www.HOPbenefits.com and click on “Find a Pharmacy” or you can call OptumRx (phone numbers are on the cover).

What if you need a specialized pharmacy?

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

■ Pharmacies that supply drugs for home infusion therapy.

■ Pharmacies that supply drugs for residents of a long-term-care (LTC) facility.

■ Pharmacies that dispense certain drugs that require special handling, provider coordination, or education on their use.

■ Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use.

(Note: This scenario should happen rarely.)
To locate a specialized pharmacy, look in your Pharmacy Directory or call OptumRx (phone numbers are printed on the front cover of this booklet).

Section 2.3 Using the plan’s mail-order services

You can use our network mail-order pharmacy to fill prescriptions for what we call “maintenance” drugs. These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

When you order prescription drugs through our network mail-order pharmacy, you must order at least a 31-day, and no more than a 90-day, supply of the drug.

Generally, it takes the mail-order pharmacy up to 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If your mail order is delayed, you can receive up to a 30-day supply at retail. Have your doctor contact your retail pharmacy to call in a temporary supply. The pharmacist will contact OptumRx for approval to fill the prescription.

If you need an immediate supply of a maintenance medication, ask your physician to write two prescriptions, one for a short-term maintenance medication, for a chronic or long-term medical condition.

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call OptumRx for more information.

2. You can use the plan’s network mail-order services. With the mail-order service, you can order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply of maintenance drugs on our plan’s Drug List. (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 to get a long-term supply of maintenance drugs. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call OptumRx for more information.

2. You can use the plan’s network mail-order services. With the mail-order service, you can order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

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. On the following page are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call OptumRx to see if there is a network pharmacy in your area where you can fill your prescription. (Phone numbers for OptumRx are printed on the front cover of this booklet.)

If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. To learn how to submit a paper claim, please see “How do you ask for reimbursement from the plan?” later in this section.

Note: Even if we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more than you would have if you had gone to an in-network pharmacy.

If you are traveling. If you travel and take a prescription drug on a regular basis, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our mail-order pharmacy. Network pharmacies are available throughout the country. If you need to transfer your prescription, call the pharmacy you wish to transfer the prescription from and ask them to transfer the prescription. You will need to provide the pharmacy with the new pharmacy name, phone number, and Rx number. You can also call OptumRx to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, OptumRx may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States and its territories, even for a medical emergency.

If you have a medical emergency or need urgent care. We will cover prescriptions that are filled at an out-of-network pharmacy in the U.S. if the prescriptions are related to care for a medical emergency or urgent care. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If you go to an out-of-network pharmacy, you may be responsible for paying 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 prescription.

Other times you can use an out-of-network pharmacy. We will cover your prescriptions at an out-of-network pharmacy if at least one of the following applies:

- You are trying to fill a prescription with a drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high-cost and Speciality Drugs).
- You are getting a vaccine that is medically necessary but not covered by Medicare Part B or some covered drugs that are administered in your doctor’s office.

Before you fill your prescription in either of these situations, call OptumRx to see if there is a network pharmacy in your area where you can fill your prescription. If you go to an out-of-network pharmacy for a reason listed above, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim. If you go to an out-of-network pharmacy, you may be responsible for paying 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 prescription.

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 share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.)
SECTION 3
YOUR DRUGS NEED TO BE ON THE PLAN’S “DRUG LIST”

The Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.

What is not on the Drug List?
The plan does not cover all prescription drugs.

■ In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).

■ In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are four “cost-sharing tiers” for drugs on the Drug List

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

■ Tier 1 includes generics drugs
■ Tier 2 includes preferred brand-name drugs (no generics available)
■ Tier 3 includes non-preferred brand-name drugs (generics available)
■ Tier 4 includes specialty drugs

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

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

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

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. The Drug List we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact OptumRx to find out if we cover it.

2. Visit the plan’s website (www.HQPBbenefits.com). The Drug List on the website is always the most current. Click on “Find a Drug” to go to the online search tool.

3. Call OptumRx to find out if a particular drug is on the plan’s Drug List or to ask for a copy of the list. (Phone numbers for OptumRx are on the front cover of this booklet.)

SECTION 4
THERE ARE RESTRICTIONS ON COVERAGE FOR SOME DRUGS

Section 4.1 Why do some drugs have restrictions?

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

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

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

Section 4.2 What kinds of restrictions?

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

Restricting brand-name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand-name drug and usually costs less. When a generic version of a brand-name drug is available, our network pharmacies may recommend and/or provide you the generic version. However, if your doctor has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost will be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called “prior authorization.” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.
Section 5
WHAT IF ONE OF YOUR DRUGS IS NOT COVERED IN THE WAY YOU’D LIKE IT TO BE COVERED?

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

We hope that your drug coverage will work well for you. But it’s possible that there could be a prescription drug you are currently taking, or that your provider thinks 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, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be. The plan puts each covered drug into one of four different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in. There are things you can do if your drug is not covered in the way that you’d like it to be covered. Your options depend on what type of problem you have:
  - If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
  - If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

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

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

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

To ask for a temporary supply, call OptumRx (phone numbers are on the front cover of this booklet).

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

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call OptumRx to ask for a list of covered drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you. (Phone numbers for OptumRx are printed on the front cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan’s Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.
If you 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 allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next 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 provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

**Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?**

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

You can change to another drug

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

You can ask for an exception

For a drug in Tier 2 (preferred brand-name) or Tier 3 (non-preferred brand-name), you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly. Drugs in 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 Drug List 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 might make changes to the Drug List. For example, the plan might:

- Add or remove drugs from the Drug List.
  - New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 4 in this chapter).
- Replace a brand-name drug with a generic drug.
  - We must follow Medicare requirements before we change the plan’s Drug List.

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

**Information on changes to drug coverage**

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

**Do changes to your drug coverage affect you right away?**

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- A generic drug replaces a brand-name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)
  - We may immediately remove a brand-name drug on our Drug List if we are replacing it with a generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand-name drug.
  - You or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

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

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

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

**SECTION 7 WHAT TYPES OF DRUGS ARE NOT COVERED BY THE PLAN?**

**Section 7.1 Types of drugs we do not cover**

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

If you are taking the brand-name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand-name drug. You may not get this notice before we make the change.

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

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List.
If you get drugs that are excluded, you must pay for them yourself. We won’t pay for the drugs that are listed in this section (except for certain excluded drugs covered under the Enhanced Medicare Rx Option). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7, Section 5.5 in this booklet.)

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

- Our plan’s Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration.

Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans. The Enhanced Medicare Rx Option, for which you pay a higher premium, covers certain drugs listed below. More information is provided below:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for the 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
- The Enhanced Medicare Rx Option includes additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. These drugs include:
  - Prescription drugs when used for the symptomatic relief of cough or colds
  - Prescription vitamins and mineral products except prenatal vitamins and fluoride preparations
  - Drugs used for the treatment of erectile dysfunction (Cialis, Levitra, and Viagra)

The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.)

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 drug list or call OptumRx for more information. Phone numbers for OptumRx are printed on the front cover of this booklet.)

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

SHOW YOUR PLAN MEMBERSHIP CARD WHEN YOU FILL A PRESCRIPTION

Section 8.1 Show your membership card

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

Section 8.2 What if you don’t have your membership card with you?

If you don’t have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information. If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. (You can then ask us to reimburse you for our share. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9

PART D DRUG COVERAGE IN SPECIAL SITUATIONS

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

If you’re admitted to a hospital for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage.

See the previous parts of this chapter that tell about the rules for getting drug coverage.

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

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

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

Usually, a long-term care facility (LTC) (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility’s pharmacy as long as it is part of our network. Check your Pharmacy Directory to find out if your long-term care facility’s pharmacy is part of our network. If it isn’t, or if you need more information, please contact OptumRx (phone numbers are printed on the front cover of this booklet).

What if you’re a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

Section 9.3 What if you’re a out of country resident?
If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover up to a 31-day supply, or less if your prescription is written for fewer days. During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

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

Your enrollment in the Enhanced or Basic Medicare Rx Option 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 the Enhanced or Basic Medicare Rx Option in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, if you are enrolled in both Part B and our plan at the same time, your employer or retiree group plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice and require an anti-nausea, laxative, pain medication or anti-anxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription. In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 4 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

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

If you are enrolled in the Enhanced or Basic Medicare Rx Option on a standalone basis (not enrolled in a medical plan) and 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?**

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

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree 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” and the choices you have for drug coverage.

If the coverage from the group plan is “creditable,” it means that it has drug coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn’t get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group’s benefits administrator or the employer or union.

**Section 9.6 What if you are in Medicare-certified hospice?**

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

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 4 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

**SECTION 10 PROGRAMS ON DRUG SAFETY AND MANAGING MEDICATIONS**

**Section 10.1 Programs to help members use drugs safely**

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs. We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

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

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

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get...
from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid medications from one pharmacy
- Requiring you to get all your prescriptions for opioid medications from one doctor
- Limiting the amount of opioid medications we will cover for you

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations with think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See Chapter 7 for information about how to ask for an appeal.

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

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

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take drugs at the same time, and have high drug costs. This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions 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. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You’ll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You’ll also get a personal medication list that will include all the medications you’re taking and why you take them.

It’s a good idea to have your medication review before your yearly “Wellness” visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program. If you have any questions about these programs, please contact OptumRx (phone numbers are printed on the front cover of this booklet).
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**Did you know there are programs to help people pay for their drugs?**

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

**Are you currently getting help to pay for your drugs?**

If you are in a program that helps pay for your drugs, some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call the HOP Administration Unit. (Phone numbers for the HOP Administration Unit are printed on the front cover of this booklet.)

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**SECTION 1**  
**INTRODUCTION**

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

This chapter focuses on what you pay for your Part D prescription drugs. 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 under the Enhanced Medicare Rx Option.

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

- **The plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List.”
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the four “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call the HOP Administration Unit (phone numbers are printed on the cover of this booklet). You can also find the Drug List on our website at www.HOPbenefits.com. The Drug List on the website is always the most current.

- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.
The plan’s Pharmacy Directory. In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The Pharmacy Directory has a list of pharmacies in the plan’s network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month supply).

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

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

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

SECTION 2
WHAT YOU PAY FOR A DRUG DEPENDS ON WHICH “DRUG PAYMENT STAGE” YOU ARE IN WHEN YOU GET THE DRUG

Section 2.1 What are the drug payment stages for Enhanced and Basic Medicare Rx Options members?

As shown in the table on the following page, there are “drug payment stages” for your prescription drug coverage under the Enhanced and Basic Medicare Rx Options. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan’s monthly premium regardless of the drug payment stage.

### DRUG PAYMENT STAGES FOR THE ENHANCED MEDICARE Rx OPTION

<table>
<thead>
<tr>
<th>STAGE 1</th>
<th>STAGE 2</th>
<th>STAGE 3</th>
<th>STAGE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>YEARLY DEDUCTIBLE STAGE</td>
<td>INITIAL COVERAGE STAGE</td>
<td>COVERAGE GAP STAGE</td>
<td>CATASTROPHIC COVERAGE STAGE</td>
</tr>
<tr>
<td>Because there is no deductible for the plan, this payment stage does not apply to you.</td>
<td>You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total $3,820. (Details are in Section 5 of this chapter.)</td>
<td>During this stage, you pay 25% of the price (plus a portion of the dispensing fee) for brand-name drugs and 25% for generic drugs. You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of $5,100. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 7 of this chapter.)</td>
<td>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2019).</td>
</tr>
</tbody>
</table>

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<td>COVERAGE GAP STAGE</td>
<td>CATASTROPHIC COVERAGE STAGE</td>
</tr>
<tr>
<td>You begin in this payment stage when you fill your first prescription of the year for a brand or specialty drug. During this stage, you pay the full cost of your brand-name and specialty drugs. You stay in this stage until you have paid $100 for your brand-name and specialty drugs ($100 is the amount of your deductible). There is no deductible for generic drugs. (Details are in Section 4 of this chapter.)</td>
<td>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. After you (or others on your behalf) have met your deductible, the plan pays its share of the costs of your drugs and you pay your share. You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total $3,820. (Details are in Section 5 of this chapter.)</td>
<td>During this stage, you pay 25% of the price for brand-name drugs plus a portion of the dispensing fee and 37% of the price for generic drugs. You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of $5,100. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)</td>
<td>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2019). (Details are in Section 7 of this chapter.)</td>
</tr>
</tbody>
</table>
SECTION 3
WE SEND YOU REPORTS THAT EXPLAIN PAYMENTS FOR YOUR DRUGS AND WHICH PAYMENT STAGE YOU ARE IN

Section 3.1 We send you a monthly report called the Part D “Explanation of Benefits” (the “Part D EOB”) Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

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

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

- Information for that month. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug 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.

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 when you get a prescription filled. To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- Make sure we have the information we need. There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

Section 3.3 Payments are divided across cost-sharing tiers
Every drug on the plan’s Drug List 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 1 includes generic drugs
- Tier 2 includes preferred brand-name drugs (no generics available)
- Tier 3 includes specialty drugs
- Tier 4 includes lowest cost-sharing plans

The plan has four cost-sharing tiers
Every drug on the plan’s Drug List 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 1 includes generic drugs
- Tier 2 includes preferred brand-name drugs (no generics available)
- Tier 3 includes specialty drugs
- Tier 4 includes lowest cost-sharing plans

Section 3.4 Send us information about the payments others have made for you.
Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your catastrophic costs. You should keep a record of these payments and send them to us so we can track your costs.

Check the written report we send you.
When you receive a Part D Explanation of Benefits (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call OptumRx (phone numbers are printed on the front cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4
THERE IS A DEDUCTIBLE ONLY FOR THE BASIC MEDICARE RX OPTION

Section 4.1 You stay in the Deductible Stage of the Basic Medicare Rx Option until you have paid $100 for your drugs

There is no deductible for the Enhanced Medicare Rx Option. 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.

The Deductible Stage is the first payment stage for your drug coverage under the Basic Medicare Rx Option. This stage begins when you fill your first prescription in the year. When you are in this payment stage, you must pay the full cost of your drugs until you reach the plan’s deductible amount, which is $100 for brand-name and specialty drugs. There is no deductible for generic drugs under the Basic Medicare Rx Option. For generic drugs, you begin in the Initial Coverage Stage when you fill your first generic prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

Your “full cost” is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.

The “deductible” is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share. Once you have paid $100 for your brand-name and specialty drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is 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 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 Drug List 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 1 includes generic drugs
- Tier 2 includes preferred brand-name drugs (no generics available)
Tier 3 includes non-preferred brand-name drugs (generics available)

Tier 4 includes specialty brand-name drugs

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

Your pharmacy choices

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

- a retail pharmacy that is in our plan’s network
- a pharmacy that is not in the plan’s network
- the plan’s mail-order pharmacy

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

Section 5.2 A table that shows your costs for a 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 or coinsurance.

- “Copayment” means that you pay a fixed amount each time you fill a prescription.
- “Coinsurance” means that you pay a percent of the total cost of the drug each time you fill a prescription.

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

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

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

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

Typically, the amount you pay for a prescription drug covers a full month’s supply of a covered drug. However, your doctor can prescribe less than a month’s supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month’s supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month’s supply, you will not have to pay for the full month’s supply for certain drugs.

The amount you pay when you get less than a full month’s supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month’s supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month’s supply, the amount you pay will be less.

- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the “daily cost-sharing rate”) and multiply it by the number of days of the drug you receive.

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") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3, Section 2.4.)

The table on the next page shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.


### Section 6

**During the Coverage Gap Stage, What You Pay Depends on Your Medicare Rx Option**

**Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $5,100**

If you are enrolled in the Basic Medicare Rx Option

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs. You pay 25% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) 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 moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay 25% and the plan pays the rest. For generic drugs, the amount paid by the plan does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand-name drugs and your share of the costs of generic drugs until your yearly out-of-pocket costs reach $5,100. In 2019, that amount is $5,100.

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of $5,100, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

**If you are enrolled in the Enhanced Medicare Rx Option**

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs. You pay 25% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) 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 moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay 25% and the plan pays the rest. For generic drugs, the amount paid by the plan does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand-name drugs and your share of the costs of generic drugs until your yearly out-of-pocket costs reach $5,100. In 2019, that amount is $5,100.

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of $5,100, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

### Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $3,820

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the $3,820 limit for the Initial Coverage Stage.

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

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The $100 you paid when you were in the Deductible Stage (Basic Medicare Rx Option only)
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage.

(If you were enrolled in a different Part D plan at any time during 2019, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

Payments for drugs covered under the Enhanced Medicare Rx Option that are not normally covered in a Medicare Prescription Drug Plan will not count towards your initial coverage limit or total out-of-pocket costs.

The Part D Explanation of Benefits that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the $3,820 limit in a year.

We will let you know if you reach this $3,820 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

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

<table>
<thead>
<tr>
<th>Cost-Sharing Tier</th>
<th>ENHANCED MEDICARE Rx OPTION</th>
<th>BASIC MEDICARE Rx OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$21 for a 31- to 90-day supply</td>
<td>$24 for a 31- to 90-day supply</td>
</tr>
<tr>
<td>Preferred Brand-name Drugs</td>
<td>Retail: 25% to a maximum of $150; Mail order: 25% to a maximum of $140</td>
<td>Retail: 30% to a maximum of $250; Mail order: 30% to a maximum of $225</td>
</tr>
<tr>
<td>Non-preferred Brand-name Drugs</td>
<td>Retail: 35% to a maximum of $200; Mail order: 35% to a maximum of $190</td>
<td>40%</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>Cost-Sharing Tier 4 Limited to a 30-day supply.</td>
<td>33%</td>
</tr>
</tbody>
</table>

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of $5,100, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.
Section 6.2  How Medicare calculates your out-of-pocket costs for prescription drugs

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

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

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

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage (Basic Medicare Rx Option only)
  - The Initial Coverage Stage
  - The Coverage Gap Stage

- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

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

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

- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $5,100 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

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

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan’s requirements for out-of-network coverage.
- Under the Basic Medicare Rx Option, non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Under the Enhanced Medicare Rx Option, prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under the Enhanced Medicare Rx Option that are not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers’ Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call OptumRx to let us know (phone numbers are printed on the front cover of this booklet).

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

We will help you. The Part D Explanation of Benefits (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $5,100 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and 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 7
DURING THE CATASTROPHIC COVERAGE STAGE, THE PLAN PAYS MOST OF THE COST FOR YOUR DRUGS

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

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $5,100 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.

■ Your share of the cost for a covered drug under the Enhanced Medicare Rx Option will be either coinsurance or a copayment, whichever is the larger amount:
  ■ Either coinsurance of 5% of the cost of the drug to a maximum of $100, or
  ■ A $3.40 copayment for a generic drug or a drug that is treated like a generic, and a $8.50 copayment for all other drugs.

■ Your share of the cost for a covered drug under the Basic Medicare Rx Option will be either coinsurance or a copayment, whichever is the larger amount:
  ■ Either coinsurance of 5% of the cost of the drug to a maximum of $250, or
  ■ A $3.40 copayment for a generic drug or a drug that is treated like a generic, and a $8.50 copayment for all other drugs.

■ Our plan pays the rest of the cost.

SECTION 8
WHAT YOU PAY FOR VACCINATIONS COVERED BY PART D DEPENDS ON HOW AND WHERE YOU GET THEM

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage of a number of Part D vaccines. There are two parts to our coverage of vaccinations:

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

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

1. The type of vaccine (what you are being vaccinated for).
2. Where you get the vaccine medication.
3. Who gives you the vaccine.

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

■ Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
■ Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible Stage of your benefit if you are in the Enhanced or Basic Medicare Rx Option.

Situation 1:
You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)
■ You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and the cost of giving you the vaccine.
■ Our plan will pay the remainder of the costs.

Situation 2:
You get the Part D vaccination at your doctor’s office.
■ When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
■ You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet.
■ You will be reimbursed the amount charged by the doctor less the amount 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.)

Situation 3:
You buy the Part D vaccine at your pharmacy, and then take it to your doctor’s office where they give you the vaccine.
■ You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
■ When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.
■ You will be reimbursed the amount charged by the doctor less the amount for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get “Extra Help,” we will reimburse you for this difference.)

Section 8.2 You may want to call OptumRx before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call OptumRx first whenever you are planning to get a vaccination. (Phone numbers for OptumRx are printed on the front cover of this booklet.)
■ We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
■ We can tell you how to keep your own cost down by using providers and pharmacies in our network.
■ If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.
SECTION 1  SITUATIONS IN WHICH YOU SHOULD ASK US TO PAY OUR SHARE OF THE COST OF YOUR COVERED DRUGS

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

SECTION 2  HOW TO ASK US TO PAY YOU BACK

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

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.

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

SECTION 4  OTHER SITUATIONS IN WHICH YOU SHOULD SAVE YOUR RECEIPTS AND SEND COPIES TO US

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

SECTION 5  ASKING US TO PAY OUR SHARE OF THE COSTS FOR COVERED DRUGS

CHAPTER 5

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Section 2.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.
- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.
- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.
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- 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. (Retroactive means that the first day of their enrollment has already past. 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 OptumRx for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for OptumRx are printed on the front cover of this booklet.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has information about how to make an appeal.
**SECTION 2**
**HOW TO ASK US TO PAY YOU BACK**

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

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

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’s helpful for our plan to process the information faster.
- You can get a copy of the form by calling OptumRx. The phone numbers are printed on the front cover of this booklet.
- Mail your request for payment together with any receipts to us at this address:
  - OptumRx
  - P.O. Box 29046
  - Hot Springs, AR 71903

Contact OptumRx if you have any questions (phone numbers are printed on the front cover of this booklet). If you don’t know what you should have paid, we can help. You can also call us if you want to give us more information about a request for payment you have already sent to us.

**SECTION 3**
**WE WILL CONSIDER YOUR REQUEST FOR PAYMENT AND SAY YES OR NO**

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

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

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for your share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the drug is not covered, or you did not follow all the rules, we will not pay for your share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

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

For the details on how to make this appeal, go to Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

**SECTION 4**
**OTHER SITUATIONS IN WHICH YOU SHOULD SEND YOUR RECEIPTS AND SEND COPIES TO US**

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

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

Here are two situations when you should send us copies of receipts to help us track your out-of-pocket drug costs:

1. When you buy the drug for a price that is lower than our price
   Sometimes when you are in the Deductible Stage (Basic Medicare Rx Option only) or Coverage Gap Stage, you can buy your drug at a network pharmacy for a price that is lower than our price.
   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.

2. When you get a drug through a patient assistance program offered by a drug manufacturer
   Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.
   - If you agree with the amount we are paying, you don’t have to make an appeal. If you disagree, you can make an appeal.

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

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

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

**Please note:** If we tell you that we will not pay for all or part of the drug, 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.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for your share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the drug is not covered, or you did not follow all the rules, we will not pay for your share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

**Section 4.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal**

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

For the details on how to make this appeal, go to Chapter 7 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

**SECTION 5**
**Chapter 5: Asking us to pay our share of the costs for covered drugs**

**Please note:** Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

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

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

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

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

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

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore you cannot make an appeal if you disagree with our decision.
SECTION 1  OUR PLAN MUST HONOR YOUR RIGHTS AS A MEMBER OF THE PLAN

Section 1.1 We must provide information in a way that works for you (in languages other than English, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call the HOP Administration Unit (phone numbers are printed on the front cover of this booklet). Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in 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 the HOP Administration Unit (phone numbers are printed on the back cover of this booklet) or contact Joseph E. Wasiak Jr., Assistant Executive Director, Public School Employees’ Retirement System.

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 the HOP Administration Unit. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact the HOP Administration Unit for additional information.

Section 1.2 We must treat you with fairness and respect at all times

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call the HOP Administration Unit (phone numbers are printed on the front cover of this booklet). If you have a complaint, such as a problem with wheelchair access, the HOP Administration Unit can help.

As a member of our plan, you also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don’t agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.3 We must ensure that you get timely access to your covered drugs

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

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

How do we protect the privacy of your health information?

We make sure that unauthorized people don’t see or change your records.

In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.

There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

For example, we are required to release health information to government agencies that are checking on quality of care.

Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

You have the right to 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 the HOP Administration Unit (phone numbers are printed on the front cover of this booklet).

Information about our plan

This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.

Information about our network pharmacies

For example, you have the right to get information from us about the pharmacies in our network.

For a list of the pharmacies in the plan’s network, see the Pharmacy Directory.

For more detailed information about our pharmacies, you can call OptumRx (phone numbers are printed on the front cover of this booklet) or visit our website at www.HOPBenefits.com.

Information about your coverage and rules you must follow in using your coverage

To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan’s List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

If you have questions about the rules or restrictions, please call OptumRx (phone numbers are printed on the front cover of this booklet).

Information about why something is not covered and what you can do about it

If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.

If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision.

You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.6 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 medical decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.

Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

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.
If you have any other prescription drug coverage besides our plan, you are required to tell us. Please call the HOP Administration Unit to let us know (phone numbers are printed on the front cover of this booklet).

- We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "coordination of benefits" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)

- Tell your doctor and pharmacist that you are enrolled in 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 your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
Pay what you owe. As a plan member, you are responsible for these payments:
- You must pay your plan premiums to continue being a member of our plan.
- For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your Part D prescription drugs.
- If you get any drugs that are not covered by your plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

Tell us if you move. If you are going to move, it’s important to tell us right away. Call the HOP Administration Unit (phone numbers are printed on the front cover of this booklet).

If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.

Call the HOP Administration Unit for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
- Phone numbers and calling hours for the HOP Administration Unit are printed on the front cover of this booklet.
- For more information on how to reach us, including our mailing address, please see Chapter 2.
SECTION 6
Taking your appeal to level 3 and beyond

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

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?

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

Section 7.3 Step-by-step: Making a complaint

Section 7.4 You can also make complaints about quality of care to the Beneficiary and Family-Centered Care Quality Improvement Organization

Section 7.5 You can also tell Medicare about your complaint

BACKGROUND

SECTION 1
INTRODUCTION

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.
SECTION 2
YOU CAN GET HELP FROM GOVERNMENT ORGANIZATIONS THAT ARE NOT CONNECTED WITH US

Section 2.1 Where to get more information and personalized assistance

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

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

SECTION 3
TO DEAL WITH YOUR PROBLEM, WHICH PROCESS SHOULD YOU USE?

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

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

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

| Yes |
| My problem is about benefits or coverage. |
| No |
| My problem is not about benefits or coverage. |

Go on to the next section of this chapter: Section 4: “A guide to the basics of coverage decisions and appeals.”

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.”

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:
- You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (https://www.medicare.gov).

SECTION 4
COVERAGE DECISIONS AND APPEALS

A GUIDE TO THE BASICS OF COVERAGE DECISIONS AND APPEALS

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

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

 Asking for coverage decisions

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

 Making an appeal

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

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

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

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

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

- You can call OptumRx (phone numbers are printed on the front cover of this booklet).
- To get free help from an independent organization that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- Your doctor or other provider can make a request for you. For Part D prescription drugs, your doctor or other prescriber can request a coverage determination or a Level 1 or 2 appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
There may be someone who is already legally authorized to act as your representative under state law.

If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, contact the HOP Administration Unit (phone numbers are printed on the front cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at https://www.cms.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and the person who you would like to act on your behalf. You must give us a copy of the signed form.

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

SECTION 5
YOUR PART D PRESCRIPTION DRUGS: HOW TO ASK FOR A COVERAGE DECISION OR MAKE AN APPEAL

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan’s List of Covered Drugs (Formulary). To be covered, the drug must be used for a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

This section is about your Part D drugs only. To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.

For details about what we mean by Part D drugs, the List of Covered Drugs (Formulary), rules and restrictions on coverage, and cost information, see Chapter 3 (Using the plan’s coverage for your Part D prescription drugs) and Chapter 4 (What you pay for your Part D prescription drugs).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

An initial coverage decision about your Part D drugs is called a “coverage determination.”

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

- Asking us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan’s List of Covered Drugs (Formulary)
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s List of Covered Drugs (Formulary) but we require you to get approval from us before we will cover it for you.)

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

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

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

### Which of these situations are you in?

<table>
<thead>
<tr>
<th>Situation</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need a drug that isn’t on your Drug List or need us to waive a rule or restriction on a drug we cover?</td>
<td>Start with Section 5.2 of this chapter.</td>
</tr>
<tr>
<td>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</td>
<td>Skip ahead to Section 5.4 of this chapter.</td>
</tr>
<tr>
<td>Do you want us to pay you back for a drug you have already received and paid for?</td>
<td>You can request an appeal. (This means you are asking us to reconsider.)</td>
</tr>
<tr>
<td>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</td>
<td>You can make an appeal. (This means you are asking us to reconsider.)</td>
</tr>
</tbody>
</table>

### Section 5.2 What is an exception?

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

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are 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 List of Covered Drugs (Formulary).** (We call it the “Drug List” for short.)
Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “formulary exception.”

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

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

Legal Terms

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”

The extra rules and restrictions on coverage for certain drugs include:

- Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
- Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
- Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List 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.

Legal Terms

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a “tiering exception.”

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
- If the drug you’re taking is a biological product you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.
- 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 (Specialty Drugs).
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you will usually pay the lowest tier.

Section 5.3 Important things to know about asking for exceptions

You doctor must tell us the medical reasons

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

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

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

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

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

Step 1: You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “fast decision.” You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do:

- Request the type of coverage decision you want. Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called How to contact us when you are asking for a coverage decision, or making an appeal and/or complaint about your Part D prescription drugs. Or if you are asking us to pay you back for a drug, go to the section called Where to send a request that asks us to pay for our share of the cost of a drug you have received.

You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. Section 4 of this chapter tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- If you want us to pay you back for a drug, start by reading Chapter 5 of this booklet, Asking us to pay our share of the costs for covered drugs. Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
If you are requesting an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can 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. See Section 5.2 and 5.3 for more information about exception requests.

We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

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

Legal Terms

A “fast coverage decision” is called an “expedited coverage determination.”

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement.

To get a fast coverage decision, you must meet two requirements:

- You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay back for a drug you already bought.)
- You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.

If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead). This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.

The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a “fast” coverage decision

If we are using the standard deadlines, we must give you our answer within 72 hours.

Generally, this means within 24 hours after we receive your request. (You are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.

If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

If we do not meet this deadline, we are also required to make payment to you within 14 calendar days after we receive your request.

If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

If we do not meet this deadline, we are also required to make payment to you within 14 calendar days after we receive your request.

If we do not meet this deadline, we are also required to make payment to you within 14 calendar days after we receive your request.

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

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

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

Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”
Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”

To start your appeal, you (or your representative or your doctor or other prescriber) must contact us:

- For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called “How to contact us when you are asking for a coverage decision, or making an appeal and/or complaint about your Part D prescription drugs.”

If you are asking for a standard appeal, make your appeal by submitting a written request. You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1, “How to contact us when you are asking for a coverage decision, or making an appeal and/or complaint about your Part D prescription drugs.”

If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1, “How to contact us when you are asking for a coverage decision, or making an appeal and/or complaint about your Part D prescription drugs.”

We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

You can ask for a copy of the information in your appeal and add more information.

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

If your health requires it, ask for a “fast appeal”

Legal Terms

A “fast appeal” is also called an “expedited redetermination.”

If you are appealing a decision 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: We consider your appeal and we give you our answer.

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

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal.
- If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)

If our answer is yes to part or all of what you requested, we will provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.

- If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadline for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health condition requires it, you should ask for a “fast” appeal.

- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

If our answer is yes to part or all of what you requested, we 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 to appeal.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

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

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

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer within 14 calendar days after we receive your request.

- If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- If our answer is yes to part or all of what you requested, we will provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.

- If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.
If we say no to your Level 1 Appeal, the
If your health requires it, ask the
Reviewers at the Independent Review
If your Level 2 Appeal is turned down and
If the Administrative Law Judge or
If the answer is yes, the appeals process
SECTION 6
TAKING YOUR APPEAL TO LEVEL 3
AND BEYOND
Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals
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 dollar value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.
For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.
Level 3 Appeal
A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

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

If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.

Deadlines for “fast appeal” at Level 2
If your health requires it, ask the Independent Review Organization for a “fast appeal.”
If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request.

Deadlines for “standard appeal” at Level 2
If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 days after it receives your appeal.
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.

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.
If we say no to your Level 1 Appeal, the written notice we send you will include instructions on how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” You have the right to ask us for a copy of your case file.
You have a right to give the Independent Review Organization additional information to support your appeal.
Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

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

If the Independent Review Organization says yes to part or all of what you requested
If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization.
If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

What if the review organization says no to your appeal?
If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.
There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you get after your second appeal.

The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5.
Section 7.1 What kinds of problems are handled by the complaint process?

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

**Level 4 Appeal**

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

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

- If the answer is no, the appeals process may or may not be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 5 Appeal**

A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

- If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.
If you have any of these kinds of problems, you can “make a complaint.”

Quality of your medical care
■ Are you unhappy with the quality of the care you have received?
Respecting your privacy
■ Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors
■ Has someone been rude or disrespectful to you?
■ Are you unhappy with how our Member Services has treated you?
■ Do you feel you are being encouraged to leave the plan?
Waiting times
■ Have you been kept waiting too long by pharmacists? Or by our Member Services or other staff at the plan?
■ Examples include waiting too long on the phone or when getting a prescription.
Cleanliness
■ Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us
■ Do you believe we have not given you a notice that we are required to give?
■ Do you think written information we have given you is hard to understand?

Possible complaints (continued)

Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)
The process of asking for a coverage decision and making appeals is explained in Section 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:
■ If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint.
■ If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
■ When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
■ When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

Legal Terms
■ What this section calls a “complaint” is also called a “grievance.”
■ Another term for “making a complaint” is “filing a grievance.”
■ Another way to say “using the process for complaints” is “using the process for filing a grievance.”

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.
■ Usually, calling OptumRx at 1-888-239-1301 is the first step. (TTY users call 1-800-498-5428.) You can call from 8 am to 5 pm ET, Monday through Friday. If there is anything else you need to do, OptumRx 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. If you do this, it means that we will use our formal procedure for answering grievances. Within this process, your complaint will be handled by the Part D Appeal & Grievance Departments in accordance with CMS guidelines. You may submit your complaint to
Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 7.4 You can also make complaints about quality of care to the Beneficiary and Family-Centered Care Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined on the previous page.

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

- You can make your complaint to the Beneficiary and Family-Centered Care Quality Improvement Organization. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
- The Beneficiary and Family-Centered Care Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
- To find the name, address, and phone number of the Beneficiary and Family-Centered Care Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

Or you can make your complaint to both at the same time. If you wish, you can make your complaint about quality of care to us and also to the Beneficiary and Family-Centered Care Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about the Enhanced or Basic Medicare Rx Option directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Legal Terms

What this section calls a “fast complaint” is also called an “expedited grievance.”

Step 2: We look into your complaint and give you our answer.

- If possible, we will answer your complaint right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- If we do not agree with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Whether you call or write, you should contact OptumRx right away. The complaint must be made within 60 days after you had the problem you want to complain about.

If you are making a complaint because you purchased or received the drug in dispute, redetermination and you have not yet denied it, and will tell you about any dispute resolution options you may have.

Exceptions to be made in accordance with CMS guidelines to accommodate extensions and expedited issues. If your grievance involves a refusal to grant an expedited coverage determination or expedited redetermination and you have not yet purchased or received the drug in dispute, the grievance ruling will be communicated to you within 24 hours of receipt.

In certain cases, you have the right to ask for a “fast complaint,” meaning we will answer your complaint within 24 hours.

OptumRx by mail or fax as follows:

- **Attn: Part D Appeals Dept, Mail Stop CA106-0266, 3515 Harbor Boulevard, Costa Mesa, CA 92626 or Fax: 1-877-239-4565**
- **Attn: Part D Grievances Dept, PO Box 3410, Lisle, IL 60532 or Fax: 1-866-235-3171**

The complaint must be submitted within 60 days of the event or incident. We must address your complaint as quickly as your case requires based on your health status, but no later than 30 days after receiving it. We may extend the time frame by up to 14 days if you ask for the extension, or if we justly need for additional information and the delay is in your best interest. If we deny your complaint in whole or in part, our written decision will explain why we deny it, and will tell you about any dispute resolution options you may have.

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<tr>
<th>Legal Terms</th>
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<tr>
<td>What this section calls a “fast complaint” is also called an “expedited grievance.”</td>
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100 Evidence of Coverage January 1 - December 31, 2019
Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)
CHAPTER 8  ENDING YOUR MEMBERSHIP IN THE PLAN

SECTION 1  INTRODUCTION

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

SECTION 2  WHEN CAN YOU END YOUR MEMBERSHIP IN OUR PLAN?

Section 2.1 Usually, you can end your membership during the Option Selection Period.

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

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

SECTION 3  HOW DO YOU END YOUR MEMBERSHIP IN OUR PLAN?

Section 3.1 Usually, you end your membership by enrolling in another plan.

SECTION 4  UNTIL YOUR MEMBERSHIP ENDS, YOU MUST KEEP GETTING YOUR DRUGS THROUGH OUR PLAN

Section 4.1 Until your membership ends, you are still a member of our plan.

SECTION 5  THE ENHANCED OR BASIC MEDICARE RX OPTION MUST END YOUR MEMBERSHIP IN THE PLAN IN CERTAIN SITUATIONS

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

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

Section 5.3 You have the right to make a complaint if we end your membership in our plan.

SECTION 6  WHEN IS THE OPTION SELECTION PERIOD?

You may end your membership in our plan only during a certain time of the year, known as the Option Selection Period. All members have the opportunity to leave the plan during the Option Selection Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

SECTION 7  ENDING YOUR MEMBERSHIP IN THE PLAN

You can end your membership during the Option Selection Period, which runs from early October through November 15 each year. This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

Note: CMS conducts a fall open enrollment each year (known as the “Annual Open Enrollment Period”). This happens from October 15 through December 7 in 2018. This is not the same as the annual Option Selection Period conducted by the Health Options Program.

When is the Option Selection Period?
This happens from early October through November 15.

What type of plan can you switch to during the Option Selection Period?
You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

− Another Medicare prescription drug plan.
− Original Medicare without a separate Medicare prescription drug plan.
− If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
− A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
Chapter 8: Ending your membership in the plan

If you enroll in most Medicare health plans, you will be disenrolled from the Enhanced or Basic Medicare Rx Option 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 and keep the Enhanced or Basic Medicare Rx Option for your drug coverage. 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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, as least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

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

In certain situations, members of the Enhanced or Basic Medicare Rx Option may be eligible to end their membership at other times of the year. This is known as a Special Enrollment Period.

Who is eligible for a Special Enrollment Period? If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples. For the full list you can contact the plan, call Medicare, or visit the Medicare website (https://www.medicare.gov):

- If you have moved out of your plan’s service area.
- 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. If you would like to know if PACE is available in your state, please contact the HGP Administration Unit (phone numbers are printed on the front cover of this booklet).

Note: If you’re in a drug management program, you may not be able to change plans.

When are Special Enrollment Periods? The enrollment periods vary depending on your situation.

What can you do? 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 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. This means you can choose any of the following types of plans:

- Another Medicare prescription drug plan.
- Original Medicare without a separate Medicare prescription drug plan.
- —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 the Enhanced or Basic Medicare Rx Option 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 and keep the Enhanced or Basic Medicare Rx Option for your drug coverage. 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.

Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.

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

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

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

- You can call the HGP Administration Unit (phone numbers are printed on the front cover of this booklet).
- You can find the information in the Medicare & You 2019 handbook.
- Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up.
- You can also download a copy from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 HOW DO YOU END YOUR MEMBERSHIP IN OUR PLAN?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods).

However, there are two situations in which you will need to end your membership in a different way:
If you want to switch from our plan to Original Medicare without a Medicare prescription drug plan, you must ask to be disenrolled from our plan.

If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep the Enhanced or Basic Medicare Rx Option for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or ask to be disenrolled from our plan.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact the HOP Administration Unit if you need more information on how to do this (phone numbers are printed on the front cover of this booklet).
- –or–You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (*Creditable* coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

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: |
<table>
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<tr>
<td>Another Medicare prescription drug plan.</td>
<td>Enroll in the new Medicare prescription drug plan between October 15 and December 7. You will automatically be disenrolled from the Enhanced or Basic Medicare Rx Option when your new plan’s coverage begins.</td>
</tr>
<tr>
<td>A Medicare health plan.</td>
<td>Enroll in the Medicare health plan by December 7. With most Medicare health plans, you will automatically be disenrolled from the Enhanced or Basic Medicare Rx Option 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 and keep the Enhanced or Basic Medicare Rx Option for your drug coverage. If you want to leave our plan, you must either enroll in another Medicare prescription drug plan or ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact the HOP Administration Unit (phone numbers are printed on the front cover of this booklet) if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).</td>
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### SECTION 4
UNTIL YOUR MEMBERSHIP ENDS, YOU MUST KEEP GETTING YOUR DRUGS THROUGH OUR PLAN

#### Section 4.1 Until your membership ends, you are still a member of our plan

If you leave the Enhanced or Basic Medicare Rx Option, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

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

### SECTION 5
THE ENHANCED OR BASIC MEDICARE RX OPTION MUST END YOUR MEMBERSHIP IN THE PLAN IN CERTAIN SITUATIONS

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

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

- If you no longer have Medicare Part A or Part B (or both).
- 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, you need to call the HOP Administration Unit to find out if the place you are moving or traveling to is in our plan’s area. (Phone numbers for the HOP Administration Unit are printed on the front cover of this booklet.)
If you become incarcerated (go to prison).
If you are not a United States citizen or lawfully present in the United States.
If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave 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 you have questions or would like more information about our decision to end your membership.
You can call the HOP Administration Unit for more information (phone numbers are printed on the front cover of this booklet).

Where can you get more information?

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

The Enhanced or Basic Medicare Rx Option is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

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

Section 5.3  You have the right to make a complaint if we end your membership in our plan

If you feel that you are being asked to leave our plan because you are lawfully present in the United States.

If you feel that you are being asked to leave our plan because of your income, and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

CHAPTER 9  LEGAL NOTICES

SECTION 1  NOTICE ABOUT GOVERNING LAW

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

SECTION 2  NOTICE ABOUT NON DISCRIMINATION

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

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, the Enhanced or Basic Medicare Rx Option, as Medicare prescription drug plan sponsors, 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.
Apartment – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don’t pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the BFCC-QIO for your state.

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 $5,100 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

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

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

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

Cost sharing – Cost sharing refers to amounts that a 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 specified drug is received. A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment.

Cost-sharing Tier – Every drug on the list of covered drugs is in one of 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 booklet. Chapter 7 explains how to ask for a coverage decision.

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.

Daily Cost-sharing Rate – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month’s supply in your plan is 30 days, then your “daily cost-sharing rate” is $1 per day. This means you pay $1 for each day’s supply when you fill your prescription.

Deductible – The amount you must pay for prescriptions before the Enhanced or Basic Medicare Rx Option begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s 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 your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a “generic” drug works the same as a brand-name drug and usually costs less.
Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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

Income Related Monthly Adjustment Amount (IRMMA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. 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 exceeded $3,820.

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

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

Low Income Subsidy – See “Extra Help.”

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

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

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE Plan, or a Medicare Advantage plan.

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

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-covered Services – Services covered by Medicare Part A and Part B.

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

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

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

Member (Member of 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 where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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

Out-of-Network Pharmacy – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, 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.” 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, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact the HOP Administration Unit (phone numbers are printed on the front cover of this booklet).
PART C – see “Medicare Advantage (MA) Plan.”

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

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

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

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

PRIOR AUTHORIZATION – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

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

SERVICE AREA – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you move out of the plan’s service area.

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

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

SUPPLEMENTAL SECURITY INCOME (SSI) – A monthly benefit paid by the Social Security Administration 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.

CHAPTER 11 FREE LANGUAGE ASSISTANCE

Pennsylvania Public School Employees’ Retirement System (PSERS) Notice of Nondiscrimination

The Pennsylvania Public School Employees’ Retirement System (PSERS) Health Options Program complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Pennsylvania Public School Employees’ Retirement System (PSERS) Health Options Program does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The PSERS Health Options Program:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Peter Camacci, Director, Health Insurance Office.

If you believe that the PSERS Health Options Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Peter Camacci, Director, Health Insurance Office
Public School Employees’ Retirement System
5 N 5th Street
Harrisburg, PA 17101-1905
Phone: (888) 773-7748; TTY use: 711; Fax: (717) 772-3860; Email: pcmacci@pa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Peter Camacci is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F; HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).

### Attention: Free Language Assistance

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

<table>
<thead>
<tr>
<th>Language</th>
<th>Message About Language Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Chinese</td>
<td>注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 1-800-773-7725; TTY: 711。</td>
</tr>
<tr>
<td>French</td>
<td>ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Italian</td>
<td>ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>PAUNAWA: Kung nagasasalin ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang wala ang bayad. Turnawag sa 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Arabic</td>
<td>محجة: إذا كنت تتحدث العربية للكور، فإن خدمات المساعدة اللغوية تتوفر لك بالمجمل. تصل برقم . TTY: 711; 1-800-773-772</td>
</tr>
<tr>
<td>Korean</td>
<td>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-773-7725; TTY: 711 번으로 전화해 주십시오.</td>
</tr>
<tr>
<td>Russian</td>
<td>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Polish</td>
<td>UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoni pod numer 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Gujarati</td>
<td>સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિશ્ચિત સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>УВАГА! Ящо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Cambodian</td>
<td>សេចក្តីសំខាន់: បើអ្នកបើកភាសាខ្មែរ ឬ យឺត-អាករមឺ ឬ យឺត-ណែរ នៅក្នុងប្រទេសចិន អ្នកមានសេវាដែលមិនគិតឈ្នួល ទូរស័ព្ទ 1-800-773-7725; TTY: 711</td>
</tr>
<tr>
<td>French Creole (Haitian)</td>
<td>ATANSYON: Si w pale Kreyl Ayisyen, gen sévò éd pou lang ki disponb gratis pou ou. Rele 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Portuguese</td>
<td>ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguisticos, gratuitos. Ligue para 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Greek</td>
<td>ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, ας διαθέσετε στη βρίσκοντας υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-773-7725; TTY: 711.</td>
</tr>
</tbody>
</table>
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.
**MEMBER SERVICES**

For help or information about prescription drugs, please call **OptumRx**.

**Phone:** 1-888-239-1301 (Calls to this number are free)

**TTY:** 1-800-498-5428 (Calls to this number are free)

**Hours:** 24 hours/7 days a week

For help or information about enrollment, billing or ID cards, please call the **HOP Administration Unit** or go to our plan website at **www.HOPbenefits.com**.

**Phone:** 1-800-773-7725 (Calls to this number are free)

**TTY:** 1-800-498-5428 (Calls to this number are free)

**Fax:** 1-877-411-4921

**Hours:** Monday—Friday, 8 am – 8 pm

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

To find a SHIP in your state, go to Chapter 2, Section 3 in this booklet.