
EVIDENCE OF COVERAGE (EOC)

Your Medicare Prescription Drug Coverage as a Member of UA Medicare Group Part D

This booklet gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2016. It explains how to get the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, UA Medicare Group Part D, is offered by United American Insurance Company. (When this Evidence of Coverage says “we,” “us,” or “our,” it means United American Insurance Company. When it says “plan” or “our plan,” it means UA Medicare Group Part D).

UA Medicare Group Part D is a PDP Plan with a Medicare contract. Enrollment in UA Medicare Group Part D depends on contract renewal.

Please contact our **Customer Service number at 1-866-524-4199** for additional information. (TTY/TDD users should call 1-866-524-4170). Hours are 8:00 am to 8:00 pm in your local time zone, weekdays. Customer Service has free language interpreter services available for Non-English speakers.

Póngase en contacto con nuestro número de servicio al cliente al 1-866-524-4199 para obtener información adicional. (Los usuarios de TTY pueden llamar 1-866-524-4170). Horas de operación son 8:00 am a 8:00 pm en su zona horaria local, siete días a la semana. Servicios al cliente tiene servicios de intérprete de lengua disponibles para hablantes de idiomas aparte de inglés.

This information is available in a different format, including large print and Braille.

Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change the year after next on January 1, 2017.

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

**Chapter 1: Getting Started As A Member Of
UA Medicare Group Part D Prescription Drug Coverage (PDP)..... 1**

Explains what it means to be in a Medicare prescription drug plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.

Chapter 2: Important Phone Numbers And Resources..... 11

Tells you how to get in touch with our plan (UA Medicare Group Part D) and with other organizations including Medicare, the State Health Insurance Assistance Program, the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

Chapter 3: Using The Plan's Coverage For Your Part D Prescription Drugs..... 23

Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan's *List of Covered Drugs* (Formulary) to find out which drugs are covered. Tells which kinds of drugs are not covered. Explains several kinds of restrictions that apply to your coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan's programs for drug safety and managing medications.

Chapter 4: What You Pay For Your Part D Prescription Drugs..... 43

Tells about the 4 stages of drug coverage (Deductible Stage, Initial Coverage Period, Coverage Gap Stage, Catastrophic Coverage Stage) and how these stages affect what you pay for your drugs. Explains the 5 cost-sharing tiers for your Part D drugs. Tells about the late enrollment penalty.

Chapter 5: Asking The Plan To Pay Its Share Of The Costs For Covered Drugs..... 61

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered drugs.

Chapter 6: Your Rights And Responsibilities	67
Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	
Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	75
Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.	
<ul style="list-style-type: none">• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules and/or extra restrictions on your coverage.• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.	
Chapter 8: Ending Your Membership In The Plan	99
Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
Chapter 9: Legal Notices	109
Includes notices about governing law and about nondiscrimination.	
Chapter 10: Definitions Of Important Words	113
Explains key terms used in this booklet.	
Appendix: State Assistance Organizations	123

Chapter 1: Getting Started As A Member Of
UA Medicare Group Part D Prescription
Drug Coverage (*PDP*)

2016 Evidence of Coverage for UA Medicare Group Part D Prescription Drug Coverage (PDP)

Chapter 1: Getting Started As A Member Of UA Medicare Group Part D Prescription Drug Coverage (PDP)

SECTION 1 Introduction

Section 1.1	You are enrolled in UA Medicare Group Part D, which is a Medicare Prescription Drug Plan	3
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?	3
Section 1.3	Legal information about the <i>Evidence of Coverage</i>	3

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

Section 2.1	Your eligibility requirements	4
Section 2.2	What are Medicare Part A and Medicare Part B?	4

SECTION 3 What other materials will you get from us?

Section 3.1	Your plan membership card – Use it to get all covered prescription drugs	4
Section 3.2	The <i>Pharmacy Directory</i> : your guide to pharmacies in our network	5
Section 3.3	The plan's <i>List of Covered Drugs (Formulary)</i>	5
Section 3.4	The <i>Part D Explanation of Benefits (the "Part D EOB")</i> : Reports with a summary of payments made for your prescription drugs	5

SECTION 4 Your monthly premium for UA Medicare Group Part D

Section 4.1	How much is the plan premium for you?	6
Section 4.2	How your plan premium is paid	7

SECTION 5 Please keep your plan membership record up to date

Section 5.1	How to help make sure that we have accurate information about you	8
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SECTION 6 We protect the privacy of your personal health information

Section 6.1	We make sure that your health information is protected	8
-------------	--	---

SECTION 7 How other insurance works with our plan

Section 7.1	Which plan pays first when you have other insurance?	9
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SECTION 1 Introduction

Section 1.1 You are enrolled in UA Medicare Group Part D, which is a Medicare Prescription Drug Plan

You are covered by Original Medicare for your health care coverage, and your employer/union benefits administrator has chosen to get your Medicare prescription drug coverage through our plan, UA Medicare Group Part D.

There are different types of Medicare plans. UA Medicare Group Part D is a Medicare prescription drug plan (*PDP*). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

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

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

The word “coverage” and “covered drugs” refers to the prescription drug coverage available to you as a member of UA Medicare Group Part D.

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 our plan’s Customer Service (*phone numbers are printed on the back 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 UA Medicare Group Part D covers your care. Other parts of this contract include the *List of Covered Drugs (Formulary)* and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in UA Medicare Group Part D Prescription Drug Coverage between January 1, 2016 to December 31, 2016.

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 UA Medicare Group Part D after December 31, 2016. We can also choose to stop offering the plan or to offer it in a different service area, after December 31, 2016.

Medicare must approve our plan each year

Medicare (*the Centers for Medicare & Medicaid Services*) must approve UA Medicare Group Part D 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 – Your employer/union has enrolled you in our plan

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

As discussed in section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through 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 how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services provided by hospitals for in-patient 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 and supplies).

SECTION 3 What other materials will you get from us?

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 our plan for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:

UAMedicare Group Part D		MedicareR Prescription Drug Coverage X Y0063 PBP #000
PRESCRIPTION DRUG COVERAGE (PDP)		
RxBin	004336	
RxPCN	MEDDADV	
RxGrp	RX8595	
Issuer	(80840) 9151014609	Effective Date
ID#	DU12345678	01-01-2016
Paula C. Holder		
Retiree of:		

SAMPLE	
MEMBERS: This card must be presented at a participating pharmacy when purchasing prescription drugs.	
SUBMIT CLAIMS TO	IMPORTANT NUMBERS
Paper Claims Dept. – Rx Claim	Customer Service 1-866-524-4169
CVS Caremark	TTY/TDD 1-866-524-4170
PO Box 52066	Provider Line 1-866-693-4620
Phoenix, AZ 85072-2066	www.uagrouppartd.com

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

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

Section 3.2 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. There are changes to our network pharmacies for next year. We included a copy of our *Pharmacy Directory* in the envelope with this booklet. An updated *Pharmacy Directory* is located on our website <http://www.uagrouppartd.com>. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2016 Pharmacy Directory to see which pharmacies are in your network.** This is important because, with few exceptions, you must get your prescriptions filled at a network pharmacy if you want our plan to cover (*help you pay for*) them.

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service (*phone numbers are printed on the back cover of this booklet*). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at <http://www.uagrouppartd.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 UA Medicare Group Part D. 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 UA Medicare Group Part D Drug List.

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

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (<http://www.uagrouppartd.com>) or call Customer Service (*phone numbers are printed on the back cover of this booklet*).

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

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

The *Part D Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. If your employer/union has elected to provide other prescription drug benefits in addition to a Medicare

2016 Evidence of Coverage for UA Medicare Group Part D Prescription Drug Coverage (PDP)

Chapter 1: Getting Started As A Member Of UA Medicare Group Part D Prescription Drug Coverage (PDP)

Part D plan, your *Part D Explanation of Benefits* will include any claim amounts paid by them. Such amounts paid do not count toward your out-of-pocket costs. Refer to your Summary of Benefits to determine if your employer/union is providing other drug coverage through us to supplement your Medicare Part D plan. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

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

SECTION 4 Your monthly premium for UA Medicare Group Part D

Section 4.1 How much is the plan premium for you?

Your coverage is provided through a contract with your current employer or former employer/union. Please contact your employer/union benefits administrator for information about your plan premium.

In some situations, the plan premium for you could be less.

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

If you are *already enrolled* and getting help from one of these programs, please contact your employer/union benefits administrator for more information. The “*Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*” (*LIS Rider*) tells you about your drug coverage. We have mailed the LIS Rider separately. If this applies to you and you don’t receive the LIS Rider, please call Customer Service and ask for the “*Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*” (*LIS Rider*). Phone numbers for Customer Service are printed on the back cover of this booklet.

In some situations, the plan premium for you could be more.

In some situations, your plan premium could be more than the amount listed above in Section 4.1. Some members are required to pay a **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 late enrollment penalty is added to the plan’s monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.

- If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 4, Section 10 explains the late enrollment penalty.
- If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

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. And 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, also known as IRMAA. If your income is greater than \$85,000 for an individual (or married individuals filing separately) or greater than \$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.**
- 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 4, Section 11 of this booklet. You can also visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2016* gives information about the Medicare premiums in the section called "2016 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 2016* from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 How your plan premium is paid

Your employer/union benefits administrator determines how your plan premium is paid. If you have questions about your plan premium, please contact your employer/union benefits administrator for more information.

If your employer/union allocates a portion or all of the plan premium to you, you are required to pay your portion of the premium according to their instructions.

If we have not received the plan premium for you when it is due, a notice will be sent to your employer/union telling them your plan membership will end if we do not receive the plan premium for you within 60 days of the due date.

If we end your membership with the plan because of non-payment of premiums and you don't currently have prescription drug coverage, you should contact your group benefits administrator to see if they can assist you.

If we end your membership due to non-payment of premiums, you will have coverage under Original Medicare. At the time we end your membership, premiums may still be owed to us that have not been paid. If this occurs and you want to enroll again in our plan, contact your group benefits administrator. The past due premiums will need to be paid before they can enroll you.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 7 of this booklet tells how to make 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 within our grace period, you can ask Medicare to reconsider this decision by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 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.

Call Customer Service to 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 caregiver*) changes

If any of this information changes, please let us know by calling Customer Service (*phone numbers are printed on the back cover of this booklet*).

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

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (*For more information about how our coverage works when you have other insurance, see Section 7 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 Customer Service (*phone numbers are printed on the back cover of this booklet*).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 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 7 How other insurance works with our plan

Section 7.1 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 employer/union has elected other drug coverage through us to supplement your Medicare Part D plan, it will pay after this Medicare Part D plan pays. We will coordinate benefits for both your Medicare Part D plan and other drug coverage through us when a covered claim is paid.
- 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 age 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you’re over age 65 and you or your spouse is still working, the group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2: Important Phone Numbers And Resources

SECTION 1	UA Medicare Group Part D contacts <i>(how to contact us, including how to reach Customer Service at the plan)</i>	13
SECTION 2	Medicare <i>(how to get help and information directly from the Federal Medicare program)</i>	15
SECTION 3	State Health Insurance Assistance Program <i>(free help, information, and answers to your questions about Medicare)</i>	17
SECTION 4	Quality Improvement Organization <i>(paid by Medicare to check on the quality of care for people with Medicare)</i>	17
SECTION 5	Social Security	17
SECTION 6	Medicaid <i>(a joint Federal and state program that helps with medical costs for some people with limited income and resources)</i>	18
SECTION 7	Information about programs to help people pay for their prescription drugs	19
SECTION 8	How to contact the Railroad Retirement Board	21
SECTION 9	Do you have “group insurance” or other health insurance from an employer?	22

SECTION 1 **UA Medicare Group Part D contacts** *(how to contact us, including how to reach Customer Service at the plan)*

How to contact our plan's Customer Service

For assistance with claims, billing, or member card questions, please call or write to UA Medicare Group Part D Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-866-524-4199 Calls to this number are free. We are available weekdays, 8 AM to 8 PM in your local time zone. Customer Service also has free language interpreter services for non-English speakers.
TTY/TTD	1-866-524-4170 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available weekdays, 8 AM to 8 PM in your local time zone.
FAX	1-214-544-5313
WRITE	Part D Customer Service United American Life Insurance Company P.O. Box 8080 McKinney, TX 75070
WEBSITE	http://www.uagrouppartd.com

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

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

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

Method	Coverage Decisions, and Appeals for Part D Prescription Drugs – Contact Information
CALL	1-888-698-0577 Calls to this number are free. We are available 7 days a week, 8 AM to 8 PM in your local time zone.
TTY	1-866-236-1069 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-855-633-7673
WRITE	CVS Caremark Part D Services MC109 PO Box 52000 Phoenix, AZ 85072-2000
WEBSITE	http://www.uagrouppartd.com

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

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. (*If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.*) For more information on making a complaint about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	1-866-524-4199 Calls to this number are free. We are available weekdays, 8 AM to 8 PM in your local time zone.
TTY/TTD	1-866-524-4170 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-214-544-5313

Method	Complaints about Part D prescription drugs – Contact Information
WRITE	Part D Customer Service United American Insurance Company P.O. Box 8080 McKinney, TX 75070
WEBSITE	http://www.uagrouppartd.com
MEDICARE WEBSITE	You can submit a complaint about UA Medicare Group Part D directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx

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

The coverage determination process includes determining requests that asks 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 the plan to pay its share of the cost for covered drugs*).

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

Method	Payment Requests – Contact Information
CALL	1-866-524-4199 Calls to this number are free. We are available weekdays, 8 AM to 8 PM in your local time zone.
TTY/TTD	1-866-524-4170 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available weekdays, 8 AM to 8 PM in your local time zone.
FAX	1-214-544-5313
WRITE	Part D Customer Service United American Life Insurance Company P.O. Box 8080 McKinney, TX 75070
WEBSITE	http://www.uagrouppartd.com

SECTION 2

Medicare

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

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (*permanent kidney failure requiring dialysis or a kidney transplant*).

2016 Evidence of Coverage for UA Medicare Group Part D Prescription Drug Coverage (PDP)

Chapter 2: Important Phone Numbers And Resources

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
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEB SITE	<p>http://www.medicare.gov</p> <p>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.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none">• 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 (<i>Medicare Supplement Insurance</i>) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about UA Medicare Group Part D:</p> <ul style="list-style-type: none">• Tell Medicare about your complaint: You can submit a complaint about UA Medicare Group Part D directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>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. (<i>You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</i>)</p>

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. See the Appendix for the name of your state's SHIP. Please see the Appendix for the name and contact information of the State Health Insurance Assistance Program in your state.

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

State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. State Health Insurance Assistance Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

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

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Please see the Appendix for the name and contact information of the State Quality Improvement Organization in your service area.

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

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

SECTION 5 **Social Security**

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End Stage Renal Disease and meets 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 a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security Administration
CALL	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.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am ET to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6

Medicaid

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

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

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These 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+).*) (*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 Agency for your state, listed in the Appendix.

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 your costs. 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 costs. To see if you qualify for getting "Extra Help", call:

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

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

- Contact the plan at the Customer Service number listed on the back cover of this booklet. We can help you determine if you already have evidence that confirms that you are qualified for "Extra Help" and we will tell you how to provide us with that information at the time of your call. If you do not currently have the evidence required but still believe that you qualify for "Extra Help", we will fill out a Best Available Evidence (BAE) Worksheet and forward the form to the CMS Regional office that covers your region. Once the CMS Regional Office has researched your inquiry with your state Medicaid agency, they will return the worksheet with any completed information from the State agency. If the returned worksheet confirms that you are eligible, this will be considered your Best Available Evidence.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (*excluding the dispensing fee*) is available for those brand name drugs from manufacturers. The plan pays an additional 5% and you pay the remaining 45% for your brand drugs.

2016 Evidence of Coverage for UA Medicare Group Part D Prescription Drug Coverage (PDP)

Chapter 2: Important Phone Numbers And Resources

Since you are enrolled in an employer/union group plan, please refer to your Summary of Benefits to determine if your plan has a Coverage Gap and how the Medicare Coverage Gap Discount Program will impact your cost sharing. If you are already receiving “Extra Help,” this discount program does not apply to you. In some cases, the Medicare Coverage Gap Discount Program may not reduce your copay/coinsurance for brand name prescriptions purchased after you have reached the Initial Coverage Limit because this brand name discount program has already been taken into account by your employer/union group administrator to determine your copay/coinsurance.

In case your employer/union group plan has a Coverage Gap, your Summary of Benefits explains what you are responsible to pay for cost sharing while you are in the Coverage Gap. If you are not already receiving “Extra Help,” we will automatically apply the discount when your pharmacy bills you for your prescription and your *Part D Explanation of Benefits (Part D EOB)* will show any discount provided. 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. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (*phone numbers are printed on the back cover of this booklet*). Because you are enrolled in an employer/union group plan, your experience with this program will be different than standard Medicare Part D plans.

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

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (*other than “Extra Help”*), you still get the 50% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 50% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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

What is the AIDS Drug Assistance Program (ADAP)?

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

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy. Please see the Appendix for the name and contact information of your AIDS Drugs Assistance Program.

For information on eligibility criteria, covered drugs, or how to enroll please see the Appendix for the name and contact information of your AIDS Drug Assistance Program.

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)*. 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 the Appendix*) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

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

Please see the Appendix for the name and contact information of your State Pharmaceutical Assistance Program.

SECTION 8 How to contact the Railroad Retirement Board

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

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

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEB SITE	http://www.rrb.gov

SECTION 9 **Do you have “group insurance” or other health insurance from an employer?**

If you (*or your spouse*) get benefits from your (*or your spouse's*) employer or retiree group, as a part this plan you may, call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (*or your spouse's*) employer or retiree health or drug benefits, premiums or enrollment period. You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

Chapter 3:

Using The Plan's Coverage For Your
Part D Prescription Drugs

SECTION 1 Introduction		
Section 1.1	This chapter describes your coverage for Part D drugs.....	26
Section 1.2	Basic rules for the plan’s Part D drug coverage.....	26
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.....	27
Section 2.2	Finding network pharmacies.....	27
Section 2.3	Using the plan’s mail-order services.....	28
Section 2.4	How can you get a long term supply of drugs?.....	28
Section 2.5	When can you use a pharmacy that is not in the plan’s network?.....	29
SECTION 3 Your drugs need to be on the plan’s “Drug List”		
Section 3.1	The “Drug List” tells which Part D drugs are covered.....	29
Section 3.2	There are five cost-sharing tiers for drugs on the Drug List.....	30
Section 3.3	How can you find out if a specific drug is on the Drug List?.....	30
SECTION 4 There are restrictions on coverage for some drugs		
Section 4.1	Why do some drugs have restrictions?.....	31
Section 4.2	What kinds of restrictions?.....	31
Section 4.3	Do any of these restrictions apply to your drugs?.....	32
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.....	32
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?.....	33
Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?.....	35
SECTION 6 What if your coverage changes for one of your drugs?		
Section 6.1	The Drug List can change during the year.....	35
Section 6.2	What happens if coverage changes for a drug you are taking?.....	35
SECTION 7 What types of drugs are not covered by the plan?		
Section 7.1	Types of drugs we do not cover.....	36

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1	Show your membership card.....	37
Section 8.2	What if you don't have your membership card with you?.....	37

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?.....	38
Section 9.2	What if you're a resident in a long-term care facility?.....	38
Section 9.3	What if you are taking drugs covered by Original Medicare?.....	39
Section 9.4	What if you have a Medigap (<i>Medicare Supplement Insurance</i>) policy with prescription drug coverage?.....	39
Section 9.5	What if you're also getting drug coverage from an employer or retiree group plan?.....	40
Section 9.6	What if you are in Medicare-certified Hospice?.....	40

SECTION 10 Programs on drug safety and managing medications

Section 10.1	Programs to help members use drugs safely.....	40
Section 10.2	Medication Therapy Management (<i>MTM</i>) Program to help members manage their medications.....	41



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?

We have included or will send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

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

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

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. To find out more about this coverage, see your *Medicare & You* 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 (*doctor, dentist, or other prescribers*) 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.*)
- 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 (<http://www.uagrouppartd.com>), or call Customer Service (*phone numbers are printed on the back cover*). Choose whatever is easiest for you.

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 provider 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 plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (*phone numbers are printed on the back cover*) or use the *Pharmacy Directory*.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care (LTC) facility. Usually, a long-term care facility (*such as a nursing home*) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (*not available in Puerto Rico*). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations, require special handling, provider coordination, or education on its use. (*Note: This scenario should happen rarely.*)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Customer Service (*phone numbers are printed on the back cover of this booklet*).

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail order service are marked as "**mail-order drugs**" on our Drug List.

Our plan's mail-order service allows you to order up to a 90-day supply.

To get order forms and information about filling your prescriptions by mail please contact Customer Service. If you use a mail order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 10 days. However, sometimes your mail-order pharmacy order may be delayed. Make sure you have a 25-day supply of that medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a 30-day supply and fill it at a retail network pharmacy while you wait for your mail-order supply to arrive. If your mail-order shipment is delayed, please call 1-800-473-3455 (*TTY/TDD users should call 1-800-716-3231*). We'll make sure you have your medication when you need it.

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

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (*including strength, amount, and form*) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program called Ready Fill @ Mail[®]. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 25 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of Ready Fill @ Mail[®] that automatically prepares mail order refills, please call 1-866-412-9774 (*TTY/TDD users should call 1-866-235-1069*).

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please call 1-866-412-9774 (*TTY/TDD users should call 1-866-235-1069*) to provide your communication preferences.

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

When you get a long term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply (*also called an "extended supply"*) of "maintenance" drugs on our plan's Drug List. (*Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.*) You may order this supply through mail order (*see section 2.3*) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long term supply of maintenance drugs. Some of these retail pharmacies may agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of maintenance drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.
2. For certain kinds of drugs, you can use the plan's network **mail-order services**. These drugs are marked as "**mail-order drugs**" on our plan's Drug List. Our plan's mail-order service allows you to order up to a 90-day supply of the drug. 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 might 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. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (*including high cost and unique drugs*).
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B and some covered drugs that are administered in your doctor's office.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby. (*Phone numbers are printed on the back cover of this booklet.*) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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 paying your normal share of the cost*) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (*Chapter 5, Section 2.1 explains how to ask the plan to pay you back.*)

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

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

The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, we call it the "**Drug List**" for short.

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

The drugs on the Drug List are only those covered under Medicare Part D (*earlier in this chapter, Section 1.1 explains about Part D drugs*).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- Approved by the Food and Drug Administration. *(That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)*
- -- or -- Supported by certain reference books. *(These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or its successors.)*

The Drug List for your plan is dependent upon the plan and coverage selected by your employer/union benefits administrator. Different Drug Lists can have different coverage. Make sure that the Drug List you use is the correct Drug List for your plan.

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. It works just as well as the brand-name drug, but it 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 five cost-sharing tiers for drugs on the Drug List

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

- Cost-sharing tier 1 includes Preferred Generic drugs. *This is the lowest cost-sharing tier.*
- Cost-sharing tier 2 includes Generic Drugs.
- Cost-sharing tier 3 includes Preferred Brand Name Drugs.
- Cost-sharing tier 4 includes Non-Preferred Brand Name Drugs. *In most cases, this is the highest cost-sharing tier.*
- Cost-sharing tier 5 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 your *Summary of Benefits*.

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.
2. Visit the plan's web site (<http://www.uagrouppartd.com>). The Drug List on the web site is always the most current.

3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are printed on the back cover of this booklet.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

In general, our rules encourage you to get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work medically just as well 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 strength, amount, or form of the drug prescribed by your health care provider *(for instance, 10mg versus 100mg; one per day versus two per day; tablet versus liquid)*.

Section 4.2 What kinds of restrictions?

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

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 will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider 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 may be greater for the brand-name drug than for the generic drug.)*

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **“Step Therapy.”**

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

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

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (*phone numbers are printed on the back cover*) or check our website (<http://www.uagrouppartd.com>).

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

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

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

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our 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 that 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 five different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

Your options depend on what type of problem you have:

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

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

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

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

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- – or – The drug you have been taking is **now restricted in some way** (*Section 4 in this chapter tells about restrictions*).

2. You must be in one of the situations described below:

- **For those members who are new to the plan or who were in the plan last year and aren't in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of *30 days*. If your prescription is written for fewer days we will allow multiple refills to provide up to a maximum of 30-day supply of medication. The prescription must be filled at a network pharmacy.

- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year**. The total supply will be for a maximum of 93-days. If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 93-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those who have been a member of the plan for more than 90 days and are a resident of a long-term care (LTC) facility and need a supply right away:**

We will cover one supply up to 31 days, or less if your prescription is written for fewer days. This is in addition to the above long term care transition supply.

- **For those with a change in their level of care:**

A level of care change is defined as when enrollees:

- Enter LTC facilities from hospitals or other settings;
- Leave LTC facilities and return to the community;
- Are discharged from a hospital to a home;
- End a skilled nursing facility (SNF) stay covered under Medicare Part A (*where all pharmacy charges are covered*), and must revert to coverage under their Part D plan formulary;
- Revert from hospice status to standard Medicare Part A and B benefits; or
- Are discharged from psychiatric hospitals with medication regimens that are highly individualized.

While Part A does provide reimbursement for “a limited supply” to facilitate beneficiary discharge, you must be permitted to have a full outpatient supply available to continue therapy once this limited supply is exhausted. Level of Care supplies will be available for your prescription, when appropriate, that are received at retail, home infusion, or mail order.

We do not use an early-refill restriction to limit appropriate and necessary access to your Part D benefit. In instances where you are admitted to, or discharged from, a long term care facility, we allow you to access a refill upon admission or discharge. However, we may use early-refill restrictions for safety reasons.

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

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

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you.

You can file an exception

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

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. 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 some of our cost-sharing tiers are not eligible for this type of exception.

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 about restrictions, see Section 4 in this chapter*).
- **Replace a brand-name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

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

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your doctor will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change 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, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, 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. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
- During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan 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)*).
 - Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
- Your provider will also know about this change, and can work with you to find another drug for your condition.

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

Section 7.1 Types of drugs we do not cover

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

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section (*unless our plan covers certain excluded drugs*). 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 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:

1. Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
2. Our plan cannot cover a drug purchased outside the United States and its territories.

3. 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 successor. 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 unless we offer enhanced drug coverage.

- 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, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (*You can find phone numbers and contact information for Medicaid in the Appendix*)

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 are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this 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 any time. Because you are enrolled in a employer/union group plan, please contact your group benefits administrator before you decide to leave our plan. (Chapter 8, *Ending your membership in the plan, tells 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 facility?

Usually, a long-term care (*LTC*) facility (*such as a nursing home*) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service. (*Phone numbers for Customer Service are printed on the back cover of this booklet.*)

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

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first **90 days** of your membership. The total supply will be for a maximum of **93 days**, 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.*)

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 one **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 doctor 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 UA Medicare Group Part D 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 UA Medicare Group Part D in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or UA Medicare Group Part D for the drug.

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

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

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

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

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 antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (*dosage*) of a drug you are taking.
- If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Section 10.2 Medication Therapy Management (MTM) Program to help members manage their medications

We have a program that can help our members with complex medical needs. For example, some members have several medical conditions or take different 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 programs 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 a MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program. If you have any questions about these programs, please contact Customer Service (*phone numbers are printed on the back cover of this booklet*).

Chapter 4:

What You Pay For Your Part D
Prescription Drugs

SECTION 1 Introduction		
Section 1.1	Use this chapter together with other materials (including your Summary of Benefits) that explain your drug coverage	46
Section 1.2	Types of out-of-pocket costs you may pay for covered drugs	47
SECTION 2 What you pay for a drug depends on the plan selected by your employer/union and which “drug payment stage” you are in when you get the drug, if they apply		
Section 2.1	What are the four drug payment stages?	48
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”)	49
Section 3.2	Help us keep our information about your drug payments up to date	49
SECTION 4 If the Deductible Stage applies to your employer/union group plan, you pay the full cost of your drugs during this stage		
Section 4.1	If your plan has a deductible, you stay in the Deductible Stage until you have paid the deductible amount listed in your Summary of Benefits	50
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	50
Section 5.2	Your costs for a drug	51
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	51
Section 5.4	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$3,310.	52
SECTION 6 During the Coverage Gap Stage, your Summary of Benefits shows what you pay and what the plan pays		
Section 6.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,850	53
Section 6.2	How Medicare calculates your out-of-pocket costs for prescription drugs	53

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..... **54**

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..... **55**

Section 8.2 You may want to call us at Customer Service before you get a vaccination..... **56**

SECTION 9 The Part D “late enrollment penalty”

Section 9.1 What is the Part D “late enrollment penalty”?..... **56**

Section 9.2 How much is the Part D late enrollment penalty?..... **57**

Section 9.3 In some situations, you can enroll late and not incur the penalty..... **57**

Section 9.4 What can you do if you disagree about your late enrollment penalty? **58**

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?..... **58**

Section 10.2 How much is the extra Part D amount? **59**

Section 10.3 What can you do if you disagree about paying an extra Part D amount?..... **59**

Section 10.4 What happens if you do not pay the extra Part D amount?..... **59**



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 have included or will send 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 Customer Service and ask for the “LIS Rider.” (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials (including your Summary of Benefits) 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 or are excluded from Medicare by law.

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

- **Summary of Benefits.** It will tell you the specifics of your cost sharing for your specific plan.
- **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 five cost-sharing tiers the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Customer Service (*phone numbers are printed on the back cover of this booklet*). You can also find the Drug List on our website at <http://www.uagrouppartd.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 and it tells how you can use the plan's mail order service to get certain types of drugs. It also explains how you can get a longer-term supply of a drug (such as filling a prescription for a three month's supply).

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

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

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

SECTION 2 What you pay for a drug depends on the plan selected by your employer/union and which “drug payment stage” you are in when you get the drug, if they apply

Section 2.1 What are the four drug payment stages?

As shown in the following table, there are typically four “drug payment stages” for prescription drug coverage. The plan selected by your employer/union will determine if your plan has a deductible and how these stages will apply, if any. Refer to your Summary of Benefits for details specific to your plan. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

<p>Stage 1</p>	<p>Yearly Deductible Stage</p>	<p>If your plan has a deductible, you begin in this stage when you fill your first prescription of the year. During this stage you pay the full cost of your drugs.</p> <p>You stay in this stage until you have paid the deductible listed for your plan in your Summary of Benefits.</p> <p><i>(Details are in Section 4 of this chapter.)</i></p>
<p>Stage 2</p>	<p>Initial Coverage Stage</p>	<p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. Your share of the cost is shown in your Summary of Benefits for your plan.</p> <p>You stay in this stage until your payments for the year plus the plan’s payments total \$3,310.</p> <p><i>(Details are in Section 5 of this chapter.)</i></p>
<p>Stage 3</p>	<p>Coverage Gap Stage</p>	<p>Refer to your Summary of Benefits to determine if your plan has a Coverage Gap and what you and the plan pays during this stage.</p> <p>You stay in this stage until your “out-of-pocket costs” reach a total of \$4,850. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p><i>(Details are in Section 6 of this chapter.)</i></p>
<p>Stage 4</p>	<p>Catastrophic Coverage Stage</p>	<p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. Your share of the cost is shown in your Summary of Benefits for your plan.</p> <p><i>(Details are in Section 7 of this chapter.)</i></p>

Please refer to your Summary of Benefits to determine if and how each of the payment stages may apply to you.

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

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

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

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

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

- **Information for that month.** This reports gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others paid on your behalf.
- **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.

- **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 for drug costs made by your employer/union group, a State Pharmaceutical Assistance Program, an AIDS drug assistance program (*ADAP*), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs. If your employer/union group is providing other drug coverage to you to reduce your costs in the coverage gap, they may already be reporting that information to us so you do not have to report it to us.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits (a Part D EOB)* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Customer Service (*phone numbers are printed on the back cover of this booklet*). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 **If the Deductible Stage applies to your employer/union group plan, you pay the full cost of your drugs during this stage**

Section 4.1 If your plan has a deductible, you stay in the Deductible Stage until you have paid the deductible amount listed in your Summary of Benefits

If your plan does not have a deductible, please skip to Section 5.

The Deductible Stage may be the first payment stage for your drug coverage. This stage begins when you fill your first applicable prescription in the year. You will pay a yearly deductible of the amount listed in your Summary of Benefits. **You must pay the full cost of your drugs that apply to your deductible** until you reach the plan's deductible amount. Please refer to your Summary of Benefits to determine which drug tier applies to your deductible.

- 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 the applicable deductible, if any, 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 five cost-sharing tiers

Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug. Some tiers may have the same cost-sharing as another tier.

- Cost-sharing tier 1 includes Preferred Generic drugs. *This is the lowest cost-sharing tier.*
- Cost-sharing tier 2 includes Generic Drugs.
- Cost-sharing tier 3 includes Preferred Brand Name Drugs.
- Cost-sharing tier 4 includes Non-Preferred Brand Name Drugs. *In most cases, this is the highest cost-sharing tier.*
- Cost-sharing tier 5 includes Specialty 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 Your costs for 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 your Summary of Benefits, the amount of the copayment or coinsurance depends on which cost-sharing 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*.

If you aren't sure which copayment or coinsurance applies to you or if you have any questions, call Customer Service.

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

Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill date for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 **You stay in the Initial Coverage Stage until your total drug costs for the year reach \$3,310.**

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$3,310 limit for the Initial Coverage Stage**.

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

- **What you have paid** for all the covered drugs 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 deductible you paid when you were in the Deductible Stage, if any.
 - 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 2015, the amount that plan paid during the Initial Coverage Stage also counts towards your total drug costs.*)

The *Explanation of Benefits (EOB)* that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$3,310 limit in a year.

We will let you know if you reach this \$3,310 amount. If you reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 **During the Coverage Gap Stage, your Summary of Benefits shows what you pay and what the plan pays**

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,850

When you are in the Coverage Gap Stage, you pay what is shown in your Summary of Benefits for this stage until your yearly out-of-pocket costs reach a maximum amount that Medicare has set. In 2016, that amount is \$4,850.

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 \$4,850, 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 5 of this booklet*):

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Deductible Stage. (*if applicable*)
 - The Initial Coverage Stage.
 - The Coverage Gap Stage. (*if applicable*)
- Any payments you made during this calendar year under another 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 Services. Payments made by Medicare's "Extra Help" are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for brand name drugs is included.

Moving on to the Catastrophic Coverage Stage:

When you (*or those paying on your behalf*) have spent a total of \$4,850 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 monthly premium amount paid by you and your employer/union.
- Drugs you buy outside the United States and its territories.
- Drugs that are not Part D drugs or drugs not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap, if applicable.
- Payments for your drugs that are made by group health plans including employer health plans, which may supplement your Medicare Part D plan.
- Payments for your drugs that are made by insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

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

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

- **We will help you.** The *Part D Explanation of Benefits (Part D EOB)* report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,850 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 \$4,700 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 will be either coinsurance or a copayment, whichever is the *larger* amount:
 - – *either* – coinsurance of 5% of the cost of the drug
 - – *or* – \$2.95 copayment for a generic drug or a drug that is treated like a generic. Or a \$7.40 copayment for all other drugs.
- If your Summary of Benefits specifies a lower maximum copayment, you will pay no more than the applicable copayment shown in your Summary of Benefits
- **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 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 vaccination?

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

1. **The type of vaccine** (*what you are being vaccinated for*).
 - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary)*.
 - Other vaccines are considered medical benefits. They are covered under Original Medicare.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

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

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

To show how this works, here are three common ways you might get a Part D vaccination shot. Remember you are responsible for all of the costs associated with vaccines (*including their administration*) during the Deductible and Coverage Gap Stage of your benefit.

Situation 1: You buy the 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 coinsurance *OR* copayment for the vaccine and the cost of giving you the vaccine.
- ▶ Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- ▶ When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- ▶ You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet (*Asking us to pay our share of the costs for covered drugs*).
- ▶ You will be reimbursed the amount you paid less your normal coinsurance *OR* copayment for the vaccine (*including administration*)

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 for administering the vaccine.

Section 8.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (*phone numbers are printed on the back 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 9 The Part D "late enrollment penalty"

Section 9.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty. The late enrollment penalty is an amount that is added to your Part D premium.

You or your employer/union may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. (*"Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.*) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

Section 9.2 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 had a break in 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, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2015, this average premium amount was \$33.13. This amount may change for 2016.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and round it to the nearest 10 cents. In the example here it would be 14% times \$33.13, which equals \$4.63, which rounds to \$4.60. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

There are three important things to note about this monthly premium penalty:

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

Section 9.3 In some situations, you can enroll late and not incur 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 late enrollment penalty.

A late enrollment penalty will not apply if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**."

Please note:

- Creditable coverage could include drug coverage from a former employer 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 web sites.
- For additional information about creditable coverage, please look in your *Medicare & You* 2016 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

Section 9.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Customer Service at the number on the front of this booklet to find out more about how to do this.

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

Most people enrolled in an employer/union plan will incur the standard monthly Part D premium determined for their group. However, some people will also pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (*or married individuals filing separately*) or \$170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration (*not us*), will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld by Medicare from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, unless your monthly benefit isn’t enough to cover the extra amount owed. If your benefit check isn’t enough to cover the extra amount, you will get a bill from Medicare. **You must pay extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 10.2 How much is the extra Part D amount?

If your modified adjusted gross income as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The following chart shows the extra amount based on your income.

If you filed an individual tax return and your income in 2014 was:	If you were married but filed a separate tax return and your income in 2014 was:	If you filed a joint tax return and your income in 2014 was:	Part D income-related monthly adjustment amount
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$12.70
Greater than \$107,000 and less than or equal to \$160,000		Greater than \$214,000 and less than or equal to \$320,000	\$32.80
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$52.80
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$72.90

Section 10.3 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 the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Section 10.4 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 to pay the extra amount and you do not pay it, you **will** be disenrolled from the plan and lose prescription drug coverage.

Chapter 5:

Asking The Plan To Pay Its Share Of The
Costs For Covered Drugs

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

Section 1.1	If you pay our plan's share of the cost for your covered drugs, you can ask us for payment.....	63
-------------	---	-----------

SECTION 2 How to ask us to pay you back

Section 2.1	How and where to send us your request for payment.....	64
-------------	--	-----------

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.....	65
Section 3.2	If we tell you that we will not pay for all or part of the drug, you can make an appeal.....	65

SECTION 4 Other situations in which you should save your receipts and 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.....	65
-------------	--	-----------

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 for your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (*paying you back is often called "reimbursing" you*).

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

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

If you go to an out-of-network pharmacy 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.

2. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

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

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (*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 your paperwork to a special plan that will handle the reimbursement.

- Send a copy of your receipts to us when you ask us to pay you back.

- You should ask for payment for your out-of-pocket expenses (*not for any expenses paid for by other insurance*).
- You have a 7-month period that allows us to cover most drugs you received between your enrollment date and the current time. Depending on your situation, either you or Medicare will need to pay for any out-of-network price differences.
- The plan may not pay for drugs that are not on our Drug List that you received outside of the 7-month period.

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 will help us process the information faster.
- Either download a copy of the form from our web site (<http://www.uagrouppartd.com>) or call Customer Service and ask for the form. The phone numbers for Customer Service are printed on the back cover of this booklet.

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

**United American Insurance Company
Part D Customer Service
P.O. Box 8080
McKinney, TX 75070-8080**

Please be sure to contact Customer Service if you have any questions regarding your paper claims or requests for payment (*phone numbers are printed at the back cover of this booklet*). If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

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

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

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

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the Section 5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

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

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

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

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

1. When you buy the drug for a price that is lower than the plan's price

Sometimes when you are in the Deductible Stage and 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.
- 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 the plan selected by your employer/union has a deductible or a coverage gap, it is possible we will not pay for any share of these drug costs. Sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly. Please refer to your Summary of Benefits to determine if you plan has a deductible or a coverage gap.

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 the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

Chapter 6: Your Rights And Responsibilities

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	69
Section 1.2	We must treat you with fairness and respect at all times	69
Section 1.3	We must ensure that you get timely access to your covered drugs	69
Section 1.4	We must protect the privacy of your personal health information	69
Section 1.5	We must give you information about the plan, its network of pharmacies, and your covered drugs	70
Section 1.6	We must support your right to make decisions about your care	71
Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made	72
Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected?	72
Section 1.9	How to get more information about your rights	73

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

Section 2.1	What are your responsibilities?	73
-------------	---------------------------------------	----

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 that are spoken in our plan service area, in Braille, in large print, or other alternate formats, etc.)*

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

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service *(phone numbers are printed on the back cover of this booklet)*.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE *(1-800-633-4227)*, 24 hours a day, 7 days a week and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

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, disability, religion, sex, health, ethnicity, creed *(beliefs)*, age, national origin, claims 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** 1-800-368-1019 *(TTY/TDD 1-800-537-7697)* or your local Office for Civil Rights.

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

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

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 1.4 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (*phone numbers are printed on the back cover of this booklet*).

Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs

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

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

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

- For a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.
- For more detailed information about our pharmacies, you can call Customer Service (*phone numbers are printed on the back cover of this booklet*) or visit our web site at <http://www.uagrouppartd.com>.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Customer Service (*phone numbers are on the 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 ask the plan for a decision about your coverage and 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 health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to **give someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (*including whether you want to sign one if you are in the hospital*). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with your State Department of Health.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (*phone numbers are printed on the back cover of this booklet*).

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

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

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (*beliefs*), age, or national origin, you should call the **Department of Health and Human Services' Office for Civil Rights** at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

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

Section 1.9 How to get more information about your rights

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

- You can **call Customer Service** (*phone numbers are printed on the back cover of this booklet*).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare web site (<http://www.medicare.gov>) to read or download the publication "Your Medicare Rights & Protections." (*The publication is available at: <http://www.medicare.gov/Pubs/pdf/11534.pdf>*)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

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

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
 - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know.
 - 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 7.*)
- **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, if any are allocated to you by your group benefits administrator, to continue being a member of our plan.
 - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (*a fixed amount*) OR coinsurance (*a percentage of the total cost*). Chapter 4 tells what you must pay for your Part D prescription drugs.
 - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
 - If you are required to pay a late enrollment penalty, you or your employer/union must pay the penalty 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 Customer Service (*phone numbers are printed on the back cover of this booklet*).
 - **If you move, it is also important to tell Social Security (or the Railroad Retirement Board).** You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7:

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

BACKGROUND **78**

SECTION 1 Introduction

- Section 1.1 What to do if you have a problem or concern **78**
- Section 1.2 What about the legal terms? **78**

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 **79**

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? **80**

COVERAGE DECISIONS AND APPEALS **81**

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

- Section 4.1 Asking for coverage decisions and making appeals: the big picture **81**
- Section 4.2 How to get help when you are asking for a coverage decision or making an appeal **81**

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

- Section 5.1 This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug **82**
- Section 5.2 What is an exception? **84**
- Section 5.3 Important things to know about asking for exceptions **85**
- Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception. **86**
- 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*) **88**
- Section 5.6 Step-by-step: How to make a Level 2 Appeal **90**

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. **92**

MAKING COMPLAINTS **94**

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?.....	94
Section 7.2	The formal name for “making a complaint” is “filing a grievance”.....	97
Section 7.3	Step-by-step: Making a complaint.....	97
Section 7.4	You can also make complaints about quality of care to the Quality Improvement Organization.....	98
Section 7.5	You can also tell Medicare about your complaint.....	98

BACKGROUND

SECTION 1 Introduction

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

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you will try an informal approach first: Please call us at Customer Service (*phone numbers are on the cover of this booklet*). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This chapter explains two types of formal processes for handling problems:

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

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

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

Section 1.2 What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “coverage determination,” 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.

The services of SHIP counselors are free. You will find phone numbers in the Appendix of this booklet.

You can also get help and information from Medicare

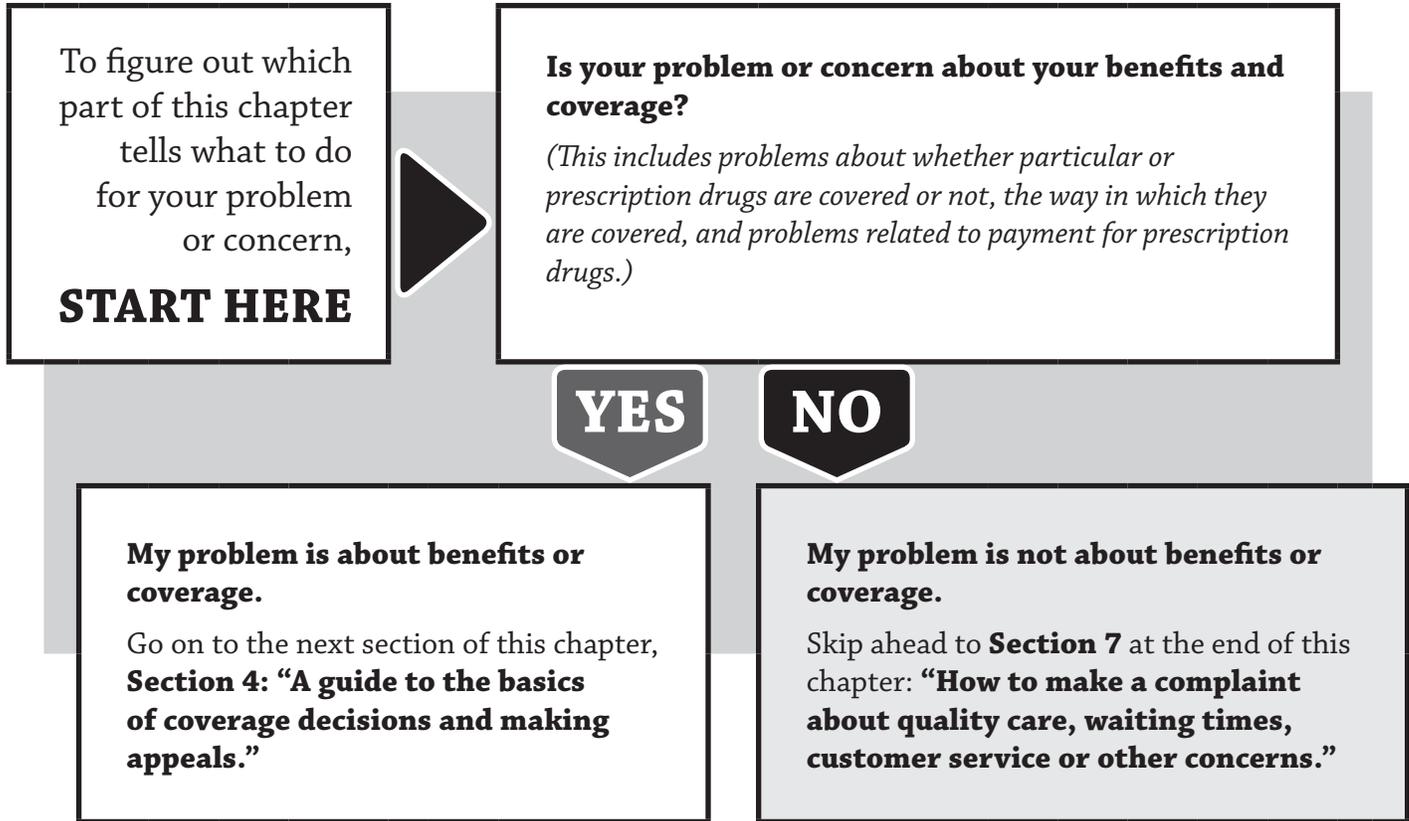
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- 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 web site (<http://www.medicare.gov>).

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

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

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



COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we have made to check to see if we were being fair and 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 will 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 additional levels of appeal.

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

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

- You can **call us at Customer Service** (*phone numbers are printed on the back cover of this booklet*).
- 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*).
- **Part D prescription drugs.** Your doctor or other prescriber can request a coverage decision 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, call Customer Service and ask for the “Appointment of Representative” form (*The form is also available on Medicare’s web site at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>*). The form gives that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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



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

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

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our plan’s *List of Covered Drugs (Formulary)* and they are 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*, rules and restrictions on coverage, and cost information, see Chapter 3 (*Using our 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 .”
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Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*
 - Asking us to waive a restriction on the plan’s coverage for a drug (*such as limits on the amount of the drug you can get*)
 - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- 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 this guide to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:

Do you need a drug that isn't on our list of drugs or need us to waive a rule or restriction on a drug we cover?

Do you want us to cover a drug for you that is on our list of drugs and you do not need us to waive a rule or restriction on the drug you need?

Do you want us to pay you back for a drug you have already received and paid for?

Has our plan 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?

This is what you can do:

You can ask us to make an exception
(This is a type of coverage decision.)
Start with **Section 5.2** of this chapter.

You can ask us for a coverage decision
Skip ahead to **Section 5.4** of this chapter.

You can ask us to pay you back
(This is a type of coverage decision.)
Skip ahead to **Section 5.4** of this chapter.

You can ask us to make an appeal
(This is means you are asking us to reconsider.)
Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

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

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our plan's List of Covered Drugs (Formulary).** (We call it the "Drug List" for short.)

LEGAL TERMS

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

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in cost-sharing tier 3, 4, or 5, depending on the drug. 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 the plan’s coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on the plan’s *List of Covered Drugs (Formulary)* (for more information, go to Chapter 3).

LEGAL TERMS	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”
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- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *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 co-insurance 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 five 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 preferred price for a covered non-preferred drug is sometimes called asking for a “tiering exception.”
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- If your drug is in cost-sharing tier 4 you can ask us to cover it at the cost-sharing amount that applies to drugs in cost-sharing tier 3. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in cost-sharing tier 1 or 5.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our Drug List includes more than 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.

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 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 us 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 web site. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug**, start by reading Chapter 5 of this booklet: *Asking us to pay our share of the costs for covered drugs*. Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (*We call this the “doctor’s statement.”*) Your doctor or other prescriber can fax or mail the statement to our plan. 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 Sections 5.2 and 5.3 for more information about exception requests.

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

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

**LEGAL
TERMS**

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

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours after we receive your doctor’s statement.
- **To get a fast 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 decision if you are asking us to pay you 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 decision,” we will automatically agree to give you a fast decision.**
 - If you ask for a fast coverage decision on your own (*without your doctor or your 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: Our plan considers your request and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage exception we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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 our plan and make your Level 1 Appeal.

If your health requires a quick response, you must ask for a “fast appeal.”

What to do

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

- For details on how to reach us by phone, fax, mail, or on our web site, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called *How to contact our plan when you are asking for a coverage decision about your Part D prescription drugs or when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** 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 about your Part D prescription drugs or when you are making an appeal 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 our plan when you are asking for a coverage decision about your Part D prescription drugs or when you are making an appeal about your Part D prescription drugs*).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our web site.
- **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. We are allowed to charge a fee for copying and sending this information to you.
 - 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 decision” in Section 5.4 of this chapter.

Step 2 We considers your appeal and we give you our answer.

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

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.

- If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (*Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.*)
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. 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**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

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 we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

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

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

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

LEGAL TERMS	The formal name for the “Independent Review Organization” is the “ Independent Review Entity .” It is sometimes called the “ IRE .”
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Step 1 To make a Level 2 Appeal, you (*or your representative*) or your doctor (*or other prescriber*) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2 The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an outside, 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 our plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for a “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for a “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested**
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

- If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. *(This is called “upholding the decision.” It is also called “turning down your appeal.”)*

- If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3 If the dollar value of the request you are requesting meets the requirement, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (*for a total of five levels of appeal*).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- Appeal Level 3 is handled by an administrative law judge. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 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 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 who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”
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- **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 **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 says no to your appeal, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**LEVEL 4
APPEAL**

The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for 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 Appeals 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 Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**LEVEL 5
APPEAL**

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

- This is the last step of the appeals process.

MAKING COMPLAINTS

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



If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

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

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

If you have any of these kinds of problems, you can “make a complaint”

Complaint:	Example:
Quality of your medical care	Are you unhappy with the quality of the care you 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?

The next page has more examples of possible reasons for making a complaint.

Possible complaints, continued

Complaint:	Example:
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> ▸ Has someone been rude or disrespectful to you? ▸ Are you unhappy with how our plan's Customer Service has dealt with you? ▸ Do you feel you are being encouraged to leave our plan?
Waiting times	<p>Have you been kept waiting too long:</p> <ul style="list-style-type: none"> ▸ By pharmacists? ▸ By Customer Service or other staff at the plan? <p>Examples include waiting too long on the phone or when getting a prescription.</p>
Cleanliness	<ul style="list-style-type: none"> ▸ Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	<ul style="list-style-type: none"> ▸ Do you believe we haven't given you a notice that we're required to give? ▸ Do you think written information we have given is hard to understand?



The next page has more examples of possible reasons for making a complaint.

Possible complaints, continued

Complaint:	Example:
<p>Timeliness <i>(These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals.)</i></p>	<p>The process of asking for a coverage decision and making appeals is explained in sections 4 – 6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.</p> <p>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:</p> <ul style="list-style-type: none">▸ 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 Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.

Phone: 1-866-524-4199

TTY/TDD: 1-866-524-4170

Hours of Operation: Weekdays, 8:00 am to 8:00 pm in your local time zone.

- **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 do this, we will respond to your complaint in writing. Here’s how it works:
 - When your grievance cannot be resolved by phone, you should write to UA Medicare Group Part D Grievance Review, P. O. Box 8080, McKinney, TX 75070. Your letter should state the nature of the grievance including the name of the person or pharmacy with whom you have a grievance and the date of the occurrence, or other details as appropriate. We will send you a letter acknowledging receipt of your written grievance within 5 days of receipt.
- **Whether you call or write, you should contact Customer Service 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 we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours**.

LEGAL TERMS

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

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered 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 do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without making the complaint to us*). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about UA Medicare Group Part D directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program

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

Chapter 8: Ending Your Membership In The Plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan..... **101**

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

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period..... **101**

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period..... **102**

Section 2.3 Where can you get more information about when you can end your membership?..... **103**

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

Section 3.1 Usually, you end your membership by enrolling in another plan..... **104**

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..... **105**

SECTION 5 UA Medicare Group Part D must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?..... **106**

Section 5.2 We cannot ask you to leave our plan for any reason related to your health..... **107**

Section 5.3 You have the right to make a complaint if we end your membership in our plan..... **107**

SECTION 1 Introduction

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

Ending your membership in UA Medicare Group Part D may be **voluntary** (*your own choice*) or **involuntary** (*not your own choice*):

- You might leave our plan because you or your group benefits administrator has decided to end your membership. **You should always check with your group benefits administrator before leaving this plan.**
 - In general, there are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you when you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- There are also limited situations where you do not chose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

Before you make any decisions to end you membership in our plan, contact your employer/union benefits administrator for more information.

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

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

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (*also known as the "Annual Coordinated Election Period"*). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

Before you make any decisions to end you membership in our plan, contact your employer/union benefits administrator for more information.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. 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
 - The 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.
- – 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 be disenrolled from UA Medicare Group Part D 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 UA Medicare Group Part D 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 to drop Medicare prescription drug coverage.

Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need 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, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 4, Section 10 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

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

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

Before you make any decisions to end you membership in our plan, contact your employer/union benefits administrator for more information.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are 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 at 1-800-MEDICARE (1-800-633-4227), or visit the Medicare web site at <http://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, live in a facility, such as a nursing home or long-term care 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 Customer Service (*phone numbers are printed on the back cover of this booklet*).
- **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
 - **If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
 - – *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 UA Medicare Group Part D 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 UA Medicare Group Part D 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 to drop Medicare prescription drug coverage.

Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need 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, at least as good as Medicare’s standard prescription drug coverage.*) See Chapter 4, Section 10 for more information about the 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 your employer/union benefits administrator.**
- You can **call Customer Service** (*phone numbers are printed on the back cover of this booklet*).
- You can find the information in the **Medicare & You 2016** 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 web site (<http://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 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 UA Medicare Group Part D 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 Customer Service if you need more information on how to do this.*)
- --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 need 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, at least as much as Medicare’s standard prescription drug coverage.*) See Chapter 4, Section 9 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:
Another Medicare prescription drug plan	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from UA Medicare Group Part D when your new plan's coverage begins.
A Medicare Health plan	<ul style="list-style-type: none"> • Enroll in the Medicare Health plan. • With most Medicare Health plans, you will automatically be disenrolled from UA Medicare Group Part D when your new plan's coverage begins. <p>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 new plan and keep UA Medicare Group Part D for your drug coverage. If you want to leave our plan, you must <i>either</i> enroll in another Medicare prescription drug plan <i>or</i> ask to be disenrolled. To ask to be disenrolled, you must send us a written request (<i>contact Customer Service if you need more information on how to do this</i>) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (<i>TTY users should call 1-877-486-2048</i>).</p>
<p>Original Medicare without a separate Medicare prescription drug plan</p> <p>Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 4, Section 9 for more information about the late enrollment penalty.</p>	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (<i>phone numbers are on the cover of this booklet</i>). • You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users should call 1-877-486-2048.

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 UA Medicare Group Part D, 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 UA Medicare Group Part D must end your membership in the plan in certain situations

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

UA Medicare Group Part D must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (*or both*).
- If you move out of our service area for more than twelve months.
 - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (*go to prison*).
- 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.*)
 - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs. (*We cannot make you leave our plan for this reason unless we get permission from Medicare first.*)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 60 days.
 - We must notify you in writing that you have 60 days to pay the plan premium before we end your membership.

Where can you get more information?

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

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

Section 5.2 **We cannot 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 we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

Chapter 9: Legal Notices

SECTION 1	Notice about governing law	111
SECTION 2	Notice about nondiscrimination	111
SECTION 3	Notice about Medicare Secondary Payer subrogation rights	111

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 nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. 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, 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, UA Medicare Group Part D, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws..

Chapter 10: Definitions Of Important Words

Appeal

An appeal is something you do if you disagree with a 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.

Annual Enrollment Period

A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

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 \$4,850 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS)

The Federal agency that administers Medicare. Section 2 explains how to contact CMS.

Coinsurance

An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles. 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

An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually 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 specific drug is received. A "daily cost sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-sharing Tier

Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

Coverage Determination

A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Covered Drugs

The term we use to mean all of the prescription drugs covered by our Plan.

Creditable Prescription Drug Coverage

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

Customer Service

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

Daily Cost-Sharing Rate

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

Deductible

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

Disenroll or Disenrollment

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

Dispensing Fee

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

Emergency

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

Evidence of Coverage (EOC) and Disclosure Information

This document, 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.

INCOME RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA) – MEDICAID (OR MEDICAL ASSISTANCE)

Income Related Monthly Adjustment Amount (IRMAA)

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 D (*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 for the year have reached \$3,310.

Initial Enrollment Period

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

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.

List of Covered Drugs (*Formulary* or "*Drug List*")

A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy (LIS)

See "Extra Help."

Medicaid (*or Medical Assistance*)

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

Medically Accepted Indication

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

Medicare

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

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

Medicare Coverage Gap Discount Program

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

Medicare-Covered Services

Services covered by Medicare Part A and Part B.

Medicare Health Plan

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

Medicare Prescription Drug Coverage (*Medicare Part D*)

Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (*Medicare Supplement Insurance*) Policy

Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage. 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 network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare

(“Traditional Medicare” or “Fee-for-service” Medicare)

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

Out-of-Network Pharmacy

A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of 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” above. A member’s cost-sharing requirement to pay for a portion of drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

PACE Plan

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

Part C

See “Medicare Advantage (*MA*) Plan”.

Part D

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

Part D Drugs

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

Preferred Cost-sharing

Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

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 (Drug List). Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO)

A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO in your state.

Quantity Limits

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

Service Area

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

Special Enrollment Period

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

Standard Cost-sharing

Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Step Therapy

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

Supplemental Security Income (SSI)

A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Appendix: State Assistance Organizations

Contact Information for

- State AIDS Drug Assistance Program (ADAP)..... 124**
- State Health Insurance Assistance Programs (SHIP)..... 130**
- State Medicaid Offices (SMO)..... 136**
- State Pharmacy Assistance Programs (SPAP)..... 142**
- State Quality Improvement Organizations (QIO)..... 147**

State AIDS Drug Assistance Program (ADAP)

ALABAMA

DELAWARE

Alabama

Division of HIV/AIDS Programs
Alabama Department of Public Health
201 Monroe Street
Montgomery, AL 36104
Local: 334-206-5300
www.adph.org/aids/

Alabama

Division of HIV/AIDS Programs
Alabama Department of Public Health
201 Monroe Street
Montgomery, AL 36104
Local: 1-334-206-5300
www.adph.org/aids/

Alaska

Alaska Division of Public Health
Alaska HIV/STD Program
3601 C Street, Suite 540
Anchorage, AK 99503
Local: 1-907-269-8000
www.epi.hss.state.ak.us/hivstd/default.stm

Arizona

Office of HIV/AIDS
Arizona Department of Health Services
150 North 18th Avenue
Phoenix, AZ 85007-3233
Local: 1-602-364-3610
www.azdhs.gov/phs/hiv/

Arkansas

STI/HIV/Hepatitis C/TB Section
Arkansas Department of Health
4815 West Markham Street, Slot 33
Little Rock, AR 72205
Local: 1-501-661-2408
[www.healthy.arkansas.gov/
programsServices/infectiousDisease/
hivStdHepatitisC/Pages/default.aspx](http://www.healthy.arkansas.gov/programsServices/infectiousDisease/hivStdHepatitisC/Pages/default.aspx)

California

Office of AIDS
California Department of Public Health
MS 7700
PO Box 997426
Sacramento, CA 95899-7426
Local: 1-916-449-5900
[www.cdph.ca.gov/programs/
aids/Pages/Default.aspx](http://www.cdph.ca.gov/programs/aids/Pages/Default.aspx)

Colorado

STD/HIV Section, DCEED-STD-A3
Colorado Department of Public Health
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Local: 1-303-692-2000
www.colorado.gov/pacific/cdphe/sti-hiv

Connecticut

Connecticut Department of Public Health
410 Capitol Avenue, MS #11APV
Hartford, CT 06134-0308
Local: 1-860-509-7801
[www.ct.gov/dph/cwp/view.
asp?a=3135&q=387010](http://www.ct.gov/dph/cwp/view.asp?a=3135&q=387010)

Delaware

Division of Public Health, HIV/AIDS Program
Delaware Health and Social Services
Thomas Collins Building
540 S. DuPont HWY
Dover, DE 19901
Local: 1-302-144-1050
[www.dhss.delaware.gov/dhss/dph/
dpc/hivaidspprogram.html](http://www.dhss.delaware.gov/dhss/dph/dpc/hivaidspprogram.html)

State AIDS Drug Assistance Program (ADAP)

DISTRICT OF COLUMBIA

KENTUCKY

District of Columbia

Care, Housing and Support Services
Bureau; HIV/AIDS, Hepatitis, STD and TB
Administration
DC Department of Health
899 North Capitol St, 4th Floor
Washington, DC 20002
Local: 1-202-442-5955
doh.dc.gov/HIV/AIDS%20Services

Florida

Bureau of HIV/AIDS
Florida Department of Health
2585 Merchants Row Blvd, Bin A09
Tallahassee, FL 32399-1715
Local: 1-850-245-4334
www.floridahealth.gov/diseases-and-conditions/aids/index.html

Georgia

Georgia Department of Public Health
2 Peachtree Street, NW, Suite 12-235
Atlanta, GA 30303-3142
Local: 1-404-657-3100
www.dph.georgia.gov/hiv-prevention-program

Hawaii

HDAP
Hawaii Department of Health
3627 Kilauea Avenue, Suite 306
Honolulu, HI 96816
Local: 1-808-733-9010
health.hawaii.gov/std-aids/

Idaho

HIV, STD, & Hepatitis Programs
Idaho Department of Health and Welfare
450 West State Street
P.O. Box 83720
Boise, ID 83720-0036
Local: 1-208-334-6527
www.healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/tabid/390

Illinois

AIDS Drug Assistance Program
Illinois Department of Public Health
525 W. Jefferson Street
Springfield, IL 62761
Local: 1-217-782-4977
www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services

Indiana

HIV/STD Division
Indiana State Department of Health
2 North Meridian St, Suite 6C
Indianapolis, IN 46204
Local: 1-317-234-1811
www.in.gov/isdh/17448.htm

Iowa

Bureau of HIV, STD, and Hepatitis
Iowa Department of Public Health
321 East, 12th Street
Des Moines, IA 50319
Local: 1-515-281-0926
www.idph.state.ia.us/hivstdhep/hiv-aids.aspx

Kansas

Disease Control and Prevention
Kansas Department of Health & Environment
1000 SW Jackson, Suite 210
Topeka, KS 66612-1274
Local: 1-785-368-6567
www.kdheks.gov/sti_hiv/

Kentucky

Cabinet for Health & Family Services, Division
of Epidemiology and Health Planning
Kentucky Department for Public Health
275 East Main Street, HS 2EC
Frankfort, KY 40621
Local: 1-502-564-6539
chfs.ky.gov/dph/epi/hiv aids.htm

State AIDS Drug Assistance Program (ADAP)

LOUISIANA

Louisiana

STD/HIV Program
Louisiana Office of Public Health
1450 Poydras Street, Suite 2136
New Orleans, LA 70112
Local: 1-504-568-7474
new.dhh.louisiana.gov/index.cfm/page/919

Maine

Ryan White Part B Program
Maine Center for Disease Control
Key Bank Building, 9th Floor
Augusta, ME 04333-0011
Local: 1-207-287-3747
www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/

Maryland

AIDS Administration and Client Services
Maryland Department of Health and Mental Hygiene
500 N. Calvert Street
Baltimore, MD 21202
Local: 1-410-767-6535
phpa.dhmh.maryland.gov/SitePages/infectious_disease.aspx

Massachusetts

HDAP
Office of HIV/AIDS
Massachusetts Department of Public Health
250 Washington Street, 3rd Floor
Boston, MA 02108-4619
Local: 1-617-624-5300
mass.gov/eohhs/gov/departments/dph/programs/id/hiv-aids

MISSOURI

Michigan

Michigan Department of Health and Human Services
109 Michigan Avenue, 9th Floor
Lansing, MI 48913
Local: 1-888-826-6565 toll-free
www.michigan.gov/mdch/0,4612,7-132-2940_2955_2982_70541-344991--,00.html

Minnesota

Program HH
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55164-0972
Local: 1-651-431-2414
mn.gov/dhs/hiv-aids

Mississippi

Prevention and Treatment Division, Office of STD/HIV
Mississippi Department of Health
570 East Woodrow Wilson Drive
Jackson, MS 39215-1700
Local: 1-601-362-4879
msdh.ms.gov/msdhsite/_static/14,0,150.html

Missouri

Prevention and Care Programs, Section of Communicable Disease Prevention
Missouri Department of Health and Senior Services
930 Wildwood Drive
Jefferson City, MO 65102-0570
Local: 1-573-751-6439
health.mo.gov/living/healthcondiseases/communicable/hiv-aids/

State AIDS Drug Assistance Program (ADAP)

MONTANA

NORTH CAROLINA

Montana

Montana Department of Public Health and
Human Services
P.O. Box 202951
Cogswell Building, Room C-211
Helena, MT 59620-9910
Local: 1-406-444-4744
dphhs.mt.gov/publichealth/hivstd

Nebraska

Nebraska Medical Center
Specialty Care Center
988106 Nebraska Medical Center
Omaha, NE 68198-8106
Local: 1-402-559-4673
[http://dhhs.ne.gov/publichealth/
Pages/dpc_ryan_white.aspx](http://dhhs.ne.gov/publichealth/Pages/dpc_ryan_white.aspx)

Nevada

Ryan White HIV/AIDS Part B (RWPB) Program
Department of Health and Human Services
4126 Technology Way
Carson City, NV 89706
Local: 1-775-684-3499
health.nv.gov/HIVcareprevention.htm

New Hampshire

New Hampshire Department of Health and
Human Services
Ryan White Care Program
29 Hazen Drive
Concord, NH 03301
Local: 1-603-271-4502 or
1-800-852-3345 ext 4502
[http://www.dhhs.nh.gov/dphs/
bchs/std/care.htm](http://www.dhhs.nh.gov/dphs/bchs/std/care.htm)

New Jersey

Division of HIV, STD, & TB Services, Aids Drug
Distribution Program
New Jersey Department of Health
ADDP
P.O. Box 722
Trenton, NJ 08625-0722
Local: 1-609-588-7038
www.nj.gov/health/aids/freemed.shtml

New Mexico

HIV/AIDS Services Program
New Mexico Department of Health - ADAP
1190 St. Francis Drive
Santa Fe, NM 87505
Local: 1-505-827-2435
[http://nmhivguide.org/
search_detail.php?id=75](http://nmhivguide.org/search_detail.php?id=75)

New York

HIV Uninsured Care Programs
AIDS Institute--Department of Health
PO Box 2052
Albany, NY 12220-0052
Local: 1-800-542-2437
www.health.ny.gov/diseases/aids/

North Carolina

The North Carolina AIDS Drug Assistance
Program (ADAP)
Communicable Disease Branch, Division of
Public Health, NC DHHS
1902 Mail Service Center (mailing)
Raleigh, NC 27699-1902
In State (Toll Free): 1-877-466-2232
Out of State: 919-733-9161
[http://epi.publichealth.nc.gov/
cd/hiv/adap.html](http://epi.publichealth.nc.gov/cd/hiv/adap.html)

State AIDS Drug Assistance Program (ADAP)

NORTH DAKOTA

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SOUTH DAKOTA

North Dakota

North Dakota Department of Health
HIV/AIDS Program
2635 East Main Ave
Bismarck, ND 58506-5520
Phone: 701-328-2378
Toll Free: 1-800-472-2180 (in-state callers only)
Confidential Fax: 701-328-0356
<http://www.ndhealth.gov/hiv/>

Ohio

Ohio HIV Drug Assistance Program (OHDAP)
HIV Care Services Section
Ohio Department of Health
246 N. High Street
Columbus, OH 43215
Phone: 800-777-4775
<https://www.odh.ohio.gov/odhprograms/hastpac/hivcare/OHDAP/drgasst1.aspx>

Oklahoma

HIV/STD Services Division
Oklahoma State Department of Health
1000 N.E. Tenth Room 614
Oklahoma City, OK 73117-1299
Local: 1-405-271-4636
[http://www.ok.gov/health/Disease, Prevention, Preparedness/HIV STD Service/Ryan White Programs/](http://www.ok.gov/health/Disease_Prevention_Preparedness/HIV_STD_Service/Ryan_White_Programs/)

Oregon

CAREAssist Program
800 NE Oregon Street Suite 1105
Portland, OR 97232
Phone: 1-800-805-2313
<http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx>

Pennsylvania

Pennsylvania Department of Health
Special Pharmaceutical Benefits Program
625 Forster Street H&W Bldg, Rm 611
Harrisburg, PA 17120
Phone: 1-800-922-9384
http://www.portal.state.pa.us/portal/server.pt/community/hiv_aids/14241/mission_statement_definition_of_aids_frequently_asked_questions/557958

Rhode Island

Ryan White AIDS Drug Assistance Program (ADAP)
Mail:
EOHHS, Hazard Building
74 West Road, Suite 60
Cranston, RI 02920
Phone: 401-462-3295
Fax: 401-462-3297
<http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/Adults/RyanWhiteHIVCareProgram.aspx>

South Carolina

South Carolina ADAP
Phone: 1-800-856-9954
<http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/>

South Dakota

Ryan White Part B CARE Program
South Dakota Department of Health
615 E. 4th St.
Pierre, SD 57501-1700
Phone: 1-800-592-1861 or 605-773-3737
<https://doh.sd.gov/diseases/infectious/ryanwhite/>

State AIDS Drug Assistance Program (ADAP)

TENNESSEE

WYOMING

Tennessee

Ryan White Part B Insurance Assistance
Program
TN Department of Health
710 James Robertson Parkway Andrew
Johnson Tower
Nashville, TN 37243
<https://health.state.tn.us/STD/ryanwhite.shtml>

Texas

Texas HIV Medication Program
Texas Department of State Health Services
1100 West 49th Street
Austin, TX 78756-3199
Phone: 1-800-255-1090
Fax: 512-533-3178
<http://www.dshs.state.tx.us/hivstd/meds/>

Utah

Utah Department of Health
Bureau of Epidemiology
288 North 1460 West Box 142104
Salt Lake City, UT 84114-2104
Phone: 801-538-6197
<http://health.utah.gov/epi/treatment/>

Vermont

Vermont Department of Health
108 Cherry Street
Burlington, VT 05402
Phone: 802-863-7245
http://healthvermont.gov/prevent/aids/aids_index.aspx#below

Virginia

HIV Care Services
Division of Disease Prevention
109 Governor Street
Richmond, VA 23219
Phone: 855-362-0658
<http://www.vdh.state.va.us/epidemiology/DiseasePrevention/Programs/ADAP/index.htm>

Washington

EIP
PO Box 47841
Olympia, WA 98501
Phone: 877-376-9316 or 360-236-3426
Fax: 360-664-2216
<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP>

West Virginia

West Virginia ADAP
350 Capitol Street
Room 125
Charleston, WV 25301
Phone: (304) 558-2195
http://www.dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx

Wisconsin

Division of Public Health
1 West Wilson Street P.O. Box 2659
Madison, WI 53701
Phone: 800-991-5532
Fax: 608-266-1288
<https://www.dhs.wisconsin.gov/aids-hiv/adap.htm>

Wyoming

Wyoming Department of Health,
Communicable Disease Unit
6101 Yellowstone Rd Suite 510
Cheyenne, WY 82002
Phone: 307-777-5886
<http://health.wyo.gov/phsd/howpa/index.html>

State Health Insurance Assistance Programs (SHIP)

ALABAMA

FLORIDA

Alabama

Alabama Department of Senior Services
201 Monroe Street, Suite 350
Montgomery, AL 36104
Phone: 1-877-425-2243
Fax: (334)242-5594
www.AlabamaAgeline.gov

Alaska

DHHS Senior and Disabilities Services
(907) 269-3680
1-800-478-6065
TTY: 1-800-770-8973
dhss.alaska.gov/dsds/Pages/medicare/default.aspx

Arizona

DES Division of Aging and Adult Services
1789 W. Jefferson St. (Site Code 950A)
Phoenix, AZ 85007
Local Phone: (602) 542-4446
Statewide Hotline: 1 (800) 432-4040 (leave message)
www.azdes.gov/daas/ship

Arkansas

Arkansas Insurance Department
Attention: SHIIP Division
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2782
1-800-224-6330
www.insurance.arkansas.gov/seniors/divpage.htm

California

California Department of Aging
1300 National Drive, Suite 200
Sacramento, CA 95834
1-800-434-0222
www.aging.ca.gov/hicap/default.aspx

Colorado

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
1-303-629-4940
1-888-696-7213
www.dora.state.co.us/insurance/senior/senior.htm

Connecticut

The Choices Program
55 Farmington Ave
Hartford, CT 06105-3730
860-424-5274 or 800-994-9422
www.ct.gov/agingservices/cwp/view.asp?a=2511&q=313032

Delaware

Delaware Medicare Assistance Bureau
1-800-336-9500 or 302-674-7364
www.delawareinsurance.gov/services/elderinfo.shtml

District of Columbia

Health Insurance Counseling Project
Jacob Burns Community Legal Clinics
The George Washington University Law School
650 20th Street, NW
Washington, DC 20052
Phone: 202-994-6272
Fax: 202-994-6441
www.law.gwu.edu/Academics/EL/Clinics/insurance/Pages/About.aspx

Florida

SHINE Program
Department of Elder Affairs
4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000
1-800-96 ELDER (1-800-963-5337)
TTY: 1-800-955-8770
www.FLORIDASHINE.org

State Health Insurance Assistance Programs (SHIP)

GEORGIA

MAINE

Georgia

GeorgiaCares
Two Peachtree Street, NW 33rd Floor
Atlanta, Georgia 30303-3142
1-866-552-4464 Option 4
www.mygeorgiacares.org

Hawaii

Sage Plus Program
Executive Office on Aging
No. 1 Capital District
250 S. Hotel St., Suite 406
Honolulu, HI 96813
(808) 586-7299 / 1-888-875-9229
TTY: 1-866-810-4379
www.hawaiiiship.org

Idaho

SHIBA
800-247-4422
www.doi.idaho.gov/shiba/shwelcome.aspx

Illinois

Illinois Department on Aging
One Natural Resources Way #100
Springfield, IL 62702
Phone: (800) 548-9034 or (217) 785-9021
TDD: (217) 524-4872
www.illinois.gov/aging

Indiana

Indiana Department of Insurance
714 W. 53rd St.
Anderson, IN 46013
Phone: (800) 452-4800
TDD: (866) 846-0139
<http://www.in.gov/idoi/2508.htm>

Iowa

SHIIP
601 Locust St. - 4th Floor
Des Moines, IA 50309-3738
Call: 1-800-351-4664
TTY: 1-800-735-2942
<http://www.therightcalliowa.gov/>

Kansas

Kansas Department on Aging
503 S. Kansas Ave.
Topeka, KS 66603
1-800-860-5260 / 785-296-0256
www.kdads.ks.gov/shick/shick_index.html

Kentucky

Department for Aging and Independent Living
275 E. Main St., 3E-E
Frankfort, KY 40621
(502) 564-6930
(877) 293-7447
TDD: 1-888-642-1137
www.chfs.ky.gov/dail/ship.htm

Louisiana

Louisiana Department of Insurance
1702 N. Third Street
Baton Rouge, LA 70802
General Info: 1-800-259-5300 or
1-800-259-5301
Direct Telephone Number: 225-342-5900
<http://www.lidi.la.gov/shiip>

Maine

Office of Aging and Disability Services
11 State House Station
(32 Blossom Lane-2nd Floor)
Augusta, ME 04333
Phone: (877) 353-3771 or 1-800-262-2232
TTY: 1-800-750-5353 or 711
<http://www.maine.gov/dhhs/oads/aging/community/ship.shtml>

State Health Insurance Assistance Programs (SHIP)

MARYLAND

Maryland

The Maryland Department of Aging
301 West Preston Street
Suite 1007
Baltimore, MD 21201
1-800-243-3425 ext 71108
[mhcc.maryland.gov/
consumerinfo/longtermcare/
SeniorHealthInsuranceProgram.aspx](http://mhcc.maryland.gov/consumerinfo/longtermcare/SeniorHealthInsuranceProgram.aspx)

Massachusetts

The SHINE Program
1-800-AGE-INFO (1-800-243-4636) option 3
410767-1100
[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)

Michigan

Michigan Office of Services to the Aging
6105 West St. Joseph, Suite 204
Lansing, MI 48917-4850
1-800-803-7174 or 517-886-0899
www.mmapinc.org

Minnesota

Statewide Health Improvement Program
Phone: 651-201-5000
Toll-free: 888-345-0823
[http://www.health.state.mn.us/
divs/oshii/ship/index.html](http://www.health.state.mn.us/divs/oshii/ship/index.html)

Mississippi

Mississippi SHIP
750 North State Street
Jackson, MS 39202
(601) 359-4929
1-800-948-3090
www.mdhs.state.ms.us/aas_ship.html

Missouri

MO Dept of Insurance, Financial Institution &
Professional Registration, CLAIM
200 North Keene Street, Suite 101
Columbia, MO 65201
Phone: (800) 390-3330 or (573) 817-8320
www.missouriclaim.org

Montana

Montana Department of Public Health &
Human Services
PO Box 4120, 2030-11th Ave
Helena, MT 59604-4210
1-800-551-3191 / 406-444-4077
TDD: 406-444-2590
[www.dphhs.mt.gov/sltc/services/
aging/SHIP/ship.shtml](http://www.dphhs.mt.gov/sltc/services/aging/SHIP/ship.shtml)

Nebraska

State of Nebraska Department of Insurance
941 O Street, Suite 400
Lincoln, NE 68508
800-234-7119
TTY: 800-833-7352
www.doi.ne.gov/shiip

Nevada

Aging and Disability Services Division
3416 Goni Road, Suite D-132
Carson City, NV 89706
(775) 687-4210
1-800-307-4444
[http://adsd.nv.gov/Programs/
Seniors/SHIP/SHIP_Prog/](http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/)

New Hampshire

NH DHHS, Bureau of Elderly & Adult Services
129 Pleasant Street
Gallen State Office Park
Concord, NH 03301-3857
1-866-634-9412 / 603-271-4394
TDD: 800-735-2964
www.nh.gov/servicelink/

NEW HAMPSHIRE

State Health Insurance Assistance Programs (SHIP)

NEW JERSEY

OREGON

New Jersey

New Jersey Department of Human Services
P.O. Box 807
Trenton, NJ 08625-0360
1-800-792-8820 / 877-222-3737
www.state.nj.us/humanservices/doas/services/ship/index.html

New Mexico

NM Aging & Long Term Services Department
2550 Cerrillos Road
Santa Fe, NM 87505
1-800-432-2080 / 505-476-4846
TTY: (505) 476-4937
www.nmaging.state.nm.us

North Carolina

North Carolina Department of Insurance
11 South Boylan Avenue
Raleigh, NC 27603
Toll-free: 855-408-1212
Fax: 919-807-6901
<http://www.ncdoi.com/SHIP/Default.aspx>

North Dakota

State Health Insurance Counseling Program (SHIC)
600 East Boulevard, Dept. 401
Bismarck, ND 58505-0320
701.328.2440
Fax: 701-328-9610
Toll-free: 888-575-6611
TTY line: 800.366.6888
<http://www.nd.gov/ndins/shic/>

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)
Ohio Department of Insurance
50 W. Town Street
Third Floor - Suite 300
Columbus, Ohio 43215
800-686-1578
Fax: 614-752-0740
<http://www.insurance.ohio.gov/aboutodi/odidiv/pages/oshiip.aspx>

Oklahoma

Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th Street Suite 100
Oklahoma City, OK 73112
1-800-763-2828 / 405-521-6628
www.ship.oid.ok.gov

Oregon

Senior Health Insurance Benefits Assistance
350 Winter St. NE, Suite 330
P.O. Box 14480
Salem, OR 97309-0405
1-800-722-4134 / 503-947-7979
TTY: 800-735-2900
Fax: (503) 947-7092
www.oregonshiba.org

Pennsylvania

Apprise
1-800-783-7067
<http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616587&mode=2>

State Health Insurance Assistance Programs (SHIP)

RHODE ISLAND

Rhode Island

RI Department of Elderly Affairs
Hazard Building,
74 West Road, 2nd Floor
Cranston, RI 02920
401-462-0510
TDD: 401-462-0740
www.dea.state.ri.us/insurance

South Carolina

Lt. Governor's Office on Aging
1301 Gervais Street, Suite 350
Columbia, SC 29202
(803) 734-9900
1-800-868-9095
www.aging.sc.gov

South Dakota

SHIINE
(605) 333-3314 - Eastern S.D.
1-800-536-8197- Eastern S.D.
(605) 224-3212 - Central S.D.
1-877-331-4834 - Central S.D.
(605) 342-8635 - Western S.D.
1-877-286-9072 - Western S.D.
www.shiine.net

Tennessee

Tennessee Commission on Aging & Disability
500 Deaderick St., 8th Floor
Nashville, TN 37243-0860
615-741-2056
1-877-801-0044
TDD: 615-532-3893
www.state.tn.us/comaging/ship.html

Texas

Health Information Counseling & Advocacy
Program of Texas (HICAP)
1-800-252-9240 or 800-252-3439
<http://www.tdi.texas.gov/consumer/hicap/hicaphme.html>

WEST VIRGINIA

Utah

Senior Health Insurance Information Program
Toll Free: 1-800-541-7735 or 801-538-3800
<http://daas.utah.gov/senior-services/>

Vermont

Department of Disabilities, Aging &
Independent Living (DAIL)
481 Summer Street, Suite 101
St. Johnsbury, VT 05819
Phone: (800) 642-5119 or (802) 748-5182
www.medicarehelpvt.net

Virginia

Department of the Aging & Rehabilitation
Services
1610 Forest Ave., Suite 100
Richmond, VA 23229
(804) 662-9333
1-800-552-3402
Fax: (804) 662-9354
TDD: 1-800-552-3402
www.vda.virginia.gov

Washington

Statewide Health Insurance Benefits Advisor
(SHIBA)
Office of the Insurance Commissioner
PO BOX 40256
Olympia, WA 98504-0256
1-800-562-6900
TDD: 360-586-0241
<http://www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/>

West Virginia

West Virginia Bureau of Senior Services
1900 Kanawha Blvd. East, 3rd Floor
Charleston, WV 25305-0160
(304) 558-3317
1-877-987-4463
Fax: (304) 558-0004
www.wvship.org

State Health Insurance Assistance Programs (SHIP)

WISCONSIN

WYOMING

Wisconsin

Department of Health Services
1 West Wilson Street, Rm 551
Madison, WI 53707
(608) 266-1865 or 1-800-242-1060
TTY: 888-701-1251
www.dhs.wisconsin.gov/aging/EBS/Ship.htm

Wyoming

WSHIIP
106 W. Adams Ave.
Riverton, WY 82501
1-800-856-4398 or 307-856-6880
www.wyomingseniors.com

State Medicaid Offices (SMO)

ALABAMA

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DISTRICT OF COLUMBIA

Alabama

Alabama Medicaid Agency
Mailing Address:
PO Box 5624
Montgomery, AL
36103-5624
Street Address:
501 Dexter Avenue
Montgomery, AL 36104
Phone: 1-334-242-5000
1-800-362-1504
www.medicaid.alabama.gov

Alaska

Senior Benefits Office
855 W. Commercial Drive,
Wasilla, AK 99654
Phone: 1-888-352-4150 or 352-4150;
Fax: 357-2561, toll-free 1-866-352-8539
[dhss.alaska.gov/dpa/pages/
medicaid/default.aspx](http://dhss.alaska.gov/dpa/pages/medicaid/default.aspx)

Arizona

AHCCS
801 E. Jefferson Street, MD 4100
Phoenix, AZ 85034
Phone: 602-417-4000
Fax: 602-252-6536
Toll-free: 1-800-654-8713 - in state
1-800-523-0231 - out of state
www.azahcccs.gov

Arkansas

Arkansas
Division of Medical Services
Department of Human Services
Donaghey Plaza South
P. O. Box 1437, Slot S401
Little Rock, AR 72203-1437
In-state toll-free: 800-482-8988
Local and out-of-state: (501) 682-8233
www.medicaid.state.ar.us

California

Medi-Cal
P.O. Box 997417, MS 4607
Sacramento, CA 95899-7413
Phone: (916) 445-4171
(916) 449-5000
www.dhcs.ca.gov

Colorado

Department of Health Care Policy and
Financing,
1570 Grant Street
Denver, CO 80203-1818
Phone: (303) 866-3513
Fax: (303) 866-4411
Toll-free: (800) 221-3943
TDD: 800-659-2656
www.colorado.gov/hcpf

Connecticut

State of Connecticut
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
Phone: 1-877-CT-HUSKY (1-877-284-8759)
TTY: 1-866-492-5276
www.huskyhealth.com

Delaware

Division of Medicaid & Medical Assistance
1901 N. Du Pont Highway, Lewis Bldg.
New Castle, DE 19720
Phone: 1-800-996-9969
Fax: (302) 255-4454
www.dhss.delaware.gov/

District of Columbia

DC Department of Health Care Finance
899 North Capitol St. NE, Suite 6037
Washington, DC 20002
Phone: (202) 442-5955
www.doh.dc.gov/

State Medicaid Offices (SMO)

FLORIDA

MAINE

Florida

Florida Agency for Health Care
Administration
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
Phone: (888) 419-3456
ahca.myflorida.com/Medicaid

Georgia

Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
Phone: (404) 656-4507
www.dch.georgia.gov/

Hawaii

Med-Quest
Phone: 1-877-628-5079
TTY/TDD: 1-855-585-8604
<http://www.med-quest.us/index.html>

Idaho

Idaho Department of Health and Welfare
Toll-free: 1-877-456-1233 / 208-334-5747
www.healthandwelfare.idaho.gov

Illinois

1-800-843-6154
Persons Using TTY:
1-800-447-6404
www.hfs.illinois.gov/programs

Indiana

Phone: (317) 713-9627
Toll-free: 1-800-457-4584
www.indianamedicaid.com

Iowa

Member Services
PO Box 36510
Des Moines, IA 50315
Phone: 800-338-8366
Fax: 515-725-1351
dhs.iowa.gov

Kansas

KanCare
Phone: 1-866-305-5147
www.kancare.ks.gov/

Kentucky

Cabinet for Health and Family Services
Office of the Secretary
275 E. Main St.
Frankfort, KY 40621
Toll-free: (800) 372-2973
TTY: 800-627-4702
www.chfs.ky.gov/dms/

Louisiana

Department of Health & Hospitals
Street Address:
628 N. 4th Street
Baton Rouge, LA 70802
Mailing Address:
P.O. Box 629
Baton Rouge, LA 70821-0629
Phone: (225)342-9500
Fax: (225)342-5568
new.dhh.louisiana.gov

Maine

Department of Health and Human Services
221 State Street
Augusta, ME 04333
Phone: 207-287-3707
Fax: 207-287-3005
TTY: 711
www.maine.gov/dhhs/index.shtml

State Medicaid Offices (SMO)

MARYLAND

Maryland

DHMH
201 W. Preston St.
Baltimore, MD 21201
Phone: (410) 767-6500
Toll-free: 1-877-463-3464
mmcp.dhmh.maryland.gov

Massachusetts

Health & Human Services Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108
Phone: (617) 573-1770
Toll-free: 1-888-665-9993
TTY: 1-888-665-9997
www.mass.gov/eohhs/gov/departments/masshealth

Michigan

MDCH
Capitol View Building
201 Townsend Street
Lansing, MI 48913
Phone: 517-373-3740
TTY: 800-649-3777
www.michigan.gov/mdch

Minnesota

Phone: (651) 431-2000
Toll-free: (800) 657-3739
TTY: (800) 627-3529
mn.gov/dhs

Mississippi

Mississippi Division of Medicaid
Sillers Building,
550 High Street Suite 1000,
Jackson, MS 39201-1399
Phone: 601-576-4111 or 601-359-6050
Toll-free: 800-421-2408
www.medicaid.ms.gov

Missouri

Mo Healthnet Division
615 Howerton Court
PO Box 6500
Jefferson City, MO 65102-6500
Telephone: (573) 751-3425
www.dss.mo.gov/mhd/

Montana

Montana Medicaid
Toll-free: 800-362-8312
dphhs.mt.gov

Nebraska

ACCESSNebraska
P.O. Box 95026
Lincoln, NE 68509-5026
Phone: 1-855-632-7633
In Lincoln: 402-473-7000
In Omaha: 402-595-1178
dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx

Nevada

Las Vegas Medicaid District Office
1210 S Valley View, Suite 104
Las Vegas, NV 89102
Local: 702-668-4200
Toll-free: 1-800-992-0900
dwss.nv.gov

New Hampshire

New Hampshire Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301
Local: 603-271-4344
Toll-free: 1-800-852-3345 ext 4344
TDD: 800-735-2964
www.dhhs.state.nh.us/ombp/medicaid/index.htm

NEW HAMPSHIRE

State Medicaid Offices (SMO)

NEW JERSEY

RHODE ISLAND

New Jersey

New Jersey Department of Human Services
Division of Medical Assistance and Health
Services
PO Box 712
Trenton, NJ 08625-0712

Toll-free: 1-800-356-1561

[www.state.nj.us/humanservices/
dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)

New Mexico

New Mexico Human Services Department
PO Box 2348
Santa Fe, NM 87504-2348

Local: 505-827-3100

Toll-free: 1-888-997-2583

www.hsd.state.nm.us/mad/

North Carolina

North Carolina Division of Medical Assistance
1985 Umstead Dr.
Raleigh, NC 27603-2001

Local: 919-855-4800

Fax: 919-733-6608

www.dhhs.state.nc.us/dma/medicaid/

North Dakota

North Dakota Department of Human
Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250

Local: 701-328- 2310

Toll-free: 1-800- 472-2622

Fax: 701-328- 2359

TTY: 800-366-6888

[www.nd.gov/dhs/services/
medicalsev/medicaid/](http://www.nd.gov/dhs/services/medicalsev/medicaid/)

Ohio

Ohio Department of Medicaid
50 West Town Street, Ste 400
Columbus, OH 43215

Phone: 800-324-8680

medicaid.ohio.gov/

Oklahoma

Oklahoma Department of Human Services
Sequoyah Memorial Office Bldg.
2400 N Lincoln Blvd,
Oklahoma City, OK 73105

Local: 405-521-3646

www.okdhs.org

Oregon

Oregon Division of Medical Assistance
Programs

Administrative Office
500 Summer Street NE
Salem, OR 97301-1079

Local: 503-945-5811 or 503-945-5921

Toll-free: 1-800-282-8096

www.oregon.gov/oha/healthplan

[www.oregon.gov/DHS/spwpd/pages/
hlth_med/healthmed.aspx](http://www.oregon.gov/DHS/spwpd/pages/hlth_med/healthmed.aspx)

Pennsylvania

The Office of Medical Assistance Programs
(OMAP)

P.O. Box 2675

Harrisburg, PA 17105-2675

Toll-free: 1-800-692-7462

www.dpw.state.pa.us/

Rhode Island

Rhode Island Department of Human Services

Phone: (401) 462-5300

Toll-free: 1-800-964-6211

www.dhs.ri.gov/

State Medicaid Offices (SMO)

SOUTH CAROLINA

South Carolina

South Carolina Department of Health & Human Services
PO Box 8206
Columbia, SC 29202-8206
Toll-free: 1-888-549-0820
www.scdhhs.gov/

South Dakota

South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501
Local: 605-773-3656
Toll-free: 1-866-854-5465
Fax: 605-773-4085
www.dss.sd.gov/

Tennessee

TennCare
310 Great Circle Rd
Nashville, TN 37243
Toll-free: 1-800-342-3145
www.state.tn.us/tenncare/

Texas

Texas Health and Human Services Commission
Brown-Heatly Building
4900 N Lamar Blvd.
Austin, TX 78751-2316
Local: 512-424-6500
Toll-free: 800-925-9126
www.hhsc.state.tx.us/medicaid/

Utah

Utah Department of Health
Division of Health Care Financing
P.O. Box 143106
Salt Lake City, UT 84114-3106
Local: 801-538-6155
Toll-free: 1-800-662-9651
Fax: 801-538-6805
www.health.utah.gov/medicaid/

WISCONSIN

Vermont

Agency of Human Services
Dept of Disabilities, Aging & Independent Living
103 South Main St.
Weeks Bldg.
Waterbury, VT 05671-1601
Phone: 802-241-2401
www.dail.vermont.gov/

Virginia

Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
Local: 804-786-6145 or 804-786-7933
Toll-free: 1-800-643-2273
TDD: 800-343-0634
www.dmas.virginia.gov/

Washington

Washington State Department of Social & Health Services
626 8th Ave. SE
Olympia, WA 98501
Toll-free: 1-800-562-3022
www.hca.wa.gov/medicaid/Pages/index.aspx

West Virginia

WV Dept of Health and Human Services
One Davis Square, Ste 100 East
Charleston, West Virginia 25301
Phone: 304-558-0684
www.dhhr.wv.gov/Pages/Contact.aspx

Wisconsin

Dept of Health Services
1 West Wilson St
Madison, WI 53703
Phone: 608-266-1865
www.dhs.wisconsin.gov/medicaid/index.htm

State Medicaid Offices (SMO)

WYOMING

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WYOMING

Wyoming

Wyoming Department of Health
401 Hathaway Bldg
Cheyenne, WY 82002
Phone: 307-777-7656
Toll-free: 1-866-571-0944
www.health.wyo.gov/default.aspx

State Pharmacy Assistance Programs (SPAP)

ALASKA

IDAHO

Alaska

SeniorCare
Senior & Disabilities Services
SeniorCare Senior Information Office
550 West 8th St.
Anchorage, AK 99501
Toll-free: 1-800-478-9996
Local: 1-907-269-3666
Fax: 1-907-269- 3688
www.hss.state.ak.us/dsds/

California

Genetically Handicapped Persons Program
MS 8100, P.O. Box 997413
Sacramento, CA 95899-7413
Local: 916-327-0470
Toll Free: 800-639-0597
Fax: 916-440-5318
www.dhcs.ca.gov/services/ghpp/Pages/default.aspx

Colorado

Colorado Bridging the Gap
Colorado Department of Public Health &
Environment
4300 Cherry Creek Drive South
Denver, CO 80246
Phone: 1-303-692-2783/1-303-692-2716
www.cdphe.state.co.us/Resources/cms/dc/HIVandSTD/RyanWhite/medicared.html

Connecticut

Connecticut Pharmaceutical Assistance
Contract to the Elderly and Disabled
(ConnPACE)
PO Box 5011
Hartford, CT 06102
Phone (In State): 1-800-423-5026
Phone (Out of state): 1-860-269-2029
www.connpace.com

Delaware (2)

Delaware Chronic Renal Disease Program
Milford State Service Center
11-13 Church Ave.
Milford, DE 19963
Local: 302-424-7180
Phone: 1-800-464-4357
www.dhss.delaware.gov/dhss/dmma/crdprog.html

Delaware Prescription Assistance Program
(DPAP)
The Division of Social Services
1901 N. Du Pont Hwy., P.O. Box 950
New Castle, DE 19720
Phone: 1-800-996-9969 Ex+2
Fax: 1-302-255-4454
www.dhss.delaware.gov/dhss/dmma/dpap.html

Florida

Florida Comprehensive Health Association
2928 Wellington Cir # 101
Tallahassee, FL 32309
Phone: 1-850-309-1200
www.flcomphealth.org

Idaho

Idaho AIDS Drug Assistance Program
IDAGAP
Department of Health and Welfare
PO Box 83720
Boise, ID 83720
Toll-free: 1-800-926-2588
Local: 208-334-5943
healthandwelfare.idaho.gov/Health/FamilyPlanningsSTDHIV/HIVCareandTreatment/tabid/391/default.aspx

State Pharmacy Assistance Programs (SPAP)

ILLINOIS

MISSOURI

Illinois

Circuit Breaker and Pharmaceutical Assistance
P.O. Box 19022
Springfield, IL 62794
Phone: (800) 624-2459
www.q1medicare.com/PartD-SPAPIllinoisProgsElderlyDisabled.php

Illinois SeniorCare
P.O. Box 19021
Springfield, IL 62794
Phone: (800) 226-0768
www.q1medicare.com/PartD-SPAPIllinoisProgsElderlyDisabled.php

Indiana

Hoosier Rx
P.O. Box 6224
Indianapolis, IN 46206-6224
Phone (In State): 1-317-234-1381
Phone (Out of state): 1-866-267-4679 (toll-free)
www.in.gov/fssa/elderly/hoosierx

Iowa

Iowa Prescription Drug Corporation
Phone: 515-327-5405
Toll Free: 1-866-282-5817
www.iowapdc.org

Maine

Office of Maine Care Services
242 State St.
Augusta, ME 04333
Toll-free: 1-866-796-2463
Fax: 1-207-287-9229
TTY: 1-800-606-0215
www.maine.gov/dhhs/beas/resource/lc_drugs.htm

Maryland (3)

Maryland Senior Prescription Drug Assistance Program
(800) 551-5995
Maryland SPDAP
c/o Pool Administrators
628 Hebron Avenue
Suite 212
Glastonbury, CT 06033
marylandspdap.com

Maryland Kidney Disease Program
(410) 767-5000
(800) 226-2142
201 West Preston Street -
Room SS-3
Baltimore, MD 21201
www.mdrxprograms.com/kdp.html

Primary Adult Care Program (PAC)
(800) 226-2142
Primary Adult Care Program
P.O. Box 386
Baltimore, MD 21203
mmcp.dhmh.maryland.gov/SitePages/Home.aspx

Massachusetts

Massachusetts Prescription Advantage
PO Box 15153 Worcester, MA 01615
Phone (In State): 1-800-243-4636 ext 2
TTY: 1-877-610-0241 M-F 9am-5pm EST
www.mass.gov/elders/healthcare/prescription-advantage

Missouri

Missouri Rx Plan
PO Box 6500
Jefferson City, MO 65102-6500
Phone: 1-800-375-1406
www.morx.mo.gov

State Pharmacy Assistance Programs (SPAP)

MONTANA (2)

UTAH

Montana (2)

Big Sky Rx Program

PO Box 202915

Helena, MT 59620

Phone (In State): 1-866-369-1233

Phone (Out of state): 1-406-444-1233

(from Helena or out of state)

dphhs.mt.gov/MontanaHealthcarePrograms/

BigSky.aspx

Mental Health Services Plan

555 Fuller Ave

PO Box 202905

Helena, MT 59620-2905

Phone (In State):

(406) 444-3964 / 800-866-0328

Fax: (406) 444-4435

www.dphhs.mt.gov/amdd/

services/mhsp.shtml

Nevada (2)

Nevada Disability Rx

3416 Goni Road, Suite D-132

Carson City, NV 89706

Phone: 1-775-687-4210

Toll-free: 1-866-303-6323

Fax: 775-687-3499

adsd.nv.gov/Programs/Physical/

DisabilityRx/DisabilityRx/

Nevada Senior Rx

Department of Health and Human Services

3416 Goni Road, Suite D-132

Carson City, NV 89706

Phone: 1-775-687-4210

Toll-free: 1-866-303-6323

Fax: 775-687-3499

adsd.nv.gov/Programs/Seniors/

SeniorRx/SrRxProg/

New Jersey (3)

Prescription Assistance to the Aged and

Disabled Program (PAAD) - HAAD

Department of Human Services

P. O. Box 715

Trenton, NJ 08625-

Phone (In State): 1-800-792-9745

www.state.nj.us/humanservices/

doas/services/paad/

Senior Gold Rx Discount Program

NJ Dept. of Health & Senior Svcs.

P. O. Box 715

Trenton, NJ 08625-0715

Local: 1-609-292-7837

1-800-792-9745

www.state.nj.us/humanservices/

doas/services/seniorgold/

New Jersey Division of Medical Assistance &

Health Services

Phone: 1-800-356-1561

NJ Department of Human Services

Division of Medical Assistance & Health

Services

P. O. Box 712

Trenton, NJ 08625

www.state.nj.us/humanservices/

dmahs/index.html

North Carolina

North Carolina HIV SPAP

877-466-2232

919-733-7301

1902 Mail Service Ctr.

Raleigh, NC 27699

epi.publichealth.nc.gov/cd/hiv/adap.html

State Pharmacy Assistance Programs (SPAP)

OREGON

TEXAS (2)

Oregon

CAREAssist Program
P.O. Box 14450
Portland, OR 97293-0450
Phone: 971-673-0144
FAX: 971-673-0177
Toll Free: 1-800-805-2313
public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx

Special Pharmaceutical Benefits Program -
Mental Health
Phone: 800-922-9384
Department of Public Welfare
SPBPMTH P. O. Box 8808
Harrisburg, PA 17105
www.dpw.state.pa.us/foradults/healthcaremedicalassistance/aids waiverprogram/specialpharmaceuticalbenefitsprogram/index.htm

Pennsylvania (4)

Pharmaceutical Assistance Contract
for the Elderly (PACE)
Magellan Health
PO Box 8806
Harrisburg, PA 17105
Phone (In State): 1-800-225-7223
Phone (Out of State): 717-651-3600
www.aging.state.pa.us/portal/server.pt/community/pace_and_affordable_medications/17942

PACE Needs Enhancement Tier (PACENET)
Commonwealth of Pennsylvania
Department of Aging
PO Box 8806
Harrisburg, PA 17105
Phone (In State): 1-800-225-7223
Phone (Out of state): 717-651-3600
Fax: 888-656-0372
pacecares.magellanhealth.com

Special Pharmaceutical Benefits Program -
HIV/AIDS
Phone: 800-922-9384
Department of Public Welfare
Special Pharmaceutical Benefits Program
P. O. Box 8021
Harrisburg, PA 17105
www.dhs.state.pa.us/foradults/healthcaremedicalassistance/aids waiverprogram/specialpharmaceuticalbenefitsprogram/index.htm

Rhode Island

Rhode Island Prescription Assistance
for the Elderly (RIPAE)
RI Department of Elderly Affairs
Hazard Bldg., 2nd Floor
74 West Road Cranston, RI 02920
Phone: 1-401-462-3000 or 1-401-462-0740
TTY: 401-462-0740
www.dea.state.ri.us/programs/prescription_assist.php

Texas (2)

Mailing Address:
Kidney Health Care Program
Department of State Health Services, MC 1938
P.O. Box 149347
Austin, TX 78714-9347
Physical Address - only for deliveries
Phone (In State): 512-776-7150
Phone (Out of state): 1-800-222-3986
Fax: (512) 776-7162
www.dshs.state.tx.us/kidney/default.shtm
TXHIV SPAP
Attn: MSJA-MC1873
P. O. Box 149347
Austin, TX 78714
Local: 512-533-3000
Toll-free: 800-255-1090 Ext 3004
www.dshs.state.tx.us/hivstd/meds/spap.shtm

State Pharmacy Assistance Programs (SPAP)

VERMONT

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WISCONSIN (4)

Vermont

V-Pharm VHAP Pharmacy
312 Hurricane Lane, Ste 201
Williston, VT 05495
Toll-free: 1-800-250-8427
Local: 1-802-879-5900
dcf.vermont.gov/esd/prescriptions

Virginia

Virginia HIV SPAP
P.O. Box 5930
Midlothian, VA 23112
Toll-free: 1-800-366-7741
www.vdh.virginia.gov/epidemiology/DiseasePrevention/index.htm

Washington

Washington State Health Insurance Pool
P.O. Box 1090
Great Bend, KS 67530
Toll-free: 1-800-877-5187
www.wship.org

Wisconsin (4)

Chronic Renal Disease
ATTN: Eligibility Unit
P.O. Box 6410
Madison, WI 53716
Toll-free: 1-800-947-9627 or 800-362-3002
www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage

Cystic Fibrosis Program
WCDP
P.O. Box 6410
Madison, WI 53716-0410
Toll-free: 1-800-947-9627 or 800-362-3002
www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage

Hemophilia Home Care
WCDP
P.O. Box 6410
Madison, WI 53716-0410
Toll-free: 1-800-947-9627 or 800-362-3002
www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage

Wisconsin SeniorCare
Department of Health Services
P.O. Box 6710
Madison, WI 53716
Toll-free: 1-800-657-2038
www.dhs.wisconsin.gov/seniorcare

For the most up-to-date information on SPAPs, please visit:
www.medicare.gov/spap.asp

State Quality Improvement Organizations (QIO)

If you live in the following States: CT, ME, MA, NH, NJ, PA, RI, VT

Please contact the following QIO program:

Method	Livanta – Contact Information
CALL	1-866-815-5440
TTY	1-866-868-2289
FAX	Appeals: 1-855-236-2423 All other reviews: 1-844-420-6671
WRITE	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701

If you live in the following States: AK, AZ, CA, HI, ID, NV, OR, WA

Please contact the following QIO program:

Method	Livanta – Contact Information
CALL	1-877-588-1123
TTY	1-855-887-6668
FAX	Appeals: 1-855-694-2929 All other reviews: 1-844-420-6672
WRITE	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701

If you live in the following States: DC, DE, FL, GA, MD, NC, SC, VA, WV

Please contact the following QIO program:

Method	KEPRO – Contact Information
CALL	1-844-455-8708
FAX	1-844-834-7129
WRITE	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609

State Quality Improvement Organizations (QIO)

If you live in the following States: AL, AR, CO, KY, LA, MS, MT, ND, NM, OK, SD, TN, TX, UT, WY

Please contact the following QIO program:

Method	KEPRO – Contact Information
CALL	1-844-430-9504
FAX	1-844-834-7129
WRITE	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131

If you live in the following States: IA, IL, IN, KS, MI, MN, MO, NE, OH, WI

Please contact the following QIO program:

Method	KEPRO – Contact Information
CALL	1-855-408-8557
FAX	1-844-834-7130
WRITE	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609

UA Medicare Group Part D Customer Service:

Method	Customer Service – Contact Information
CALL	1-866-524-4199
	Calls to this number are free. We are available 8:00 AM to 8:00 PM, 7 days a week in your local time zone. Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	1-866-524-4170
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 8:00 AM to 8:00 PM, week days in your local time zone.
FAX	1-214-544-5313
WRITE	UA Medicare Group Part D Customer Service P.O. Box 8080 McKinney, TX 75070
WEBSITE	http://www.uagrouppartd.com

The 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. Please see the Appendix of this Evidence of Coverage to find the name and contact information for the State Health Insurance Assistance Program in your state.



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