Evidence of Coverage 2025

UAW Trust MedicareRx (PDP)
Group Name (Plan Sponsor): UAW Trust (PDP)
Group Number: 25530

UAWTrustPDP.com

Toll-free **1-855-409-0219,** TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

Optum Rx®

UAW RETIREE Medical Benefits Trust

Y0066_EOC_S5820_823_000_2025_C

January 1, 2025 - December 31, 2025

Evidence of Coverage

Your Medicare Prescription Drug Coverage as a Member of our plan

This document gives you the details about your Medicare prescription drug coverage from January 1, 2025 - December 31, 2025.

This is an important legal document. Please keep it in a safe place.

For questions about this document, please contact Customer Service at 1-855-409-0219. (TTY users should call 711). Hours are 8 a.m.-8 p.m. local time, Monday-Friday.

This plan, UAW Trust MedicareRx (PDP), is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means UAW Trust MedicareRx (PDP).)

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

Benefits and/or copayments/coinsurance may change on January 1, 2026.

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

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

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

OMB Approval 0938-1051 (Expires: August 31, 2026)

Dear Member,

This Evidence of Coverage (EOC) provides you with details about your plan, the UAW Retiree Medical Benefits Trust Medicare Part D Plan (PDP), which is insured through UnitedHealthcare Insurance Company (UnitedHealthcare) or one of its affiliates. The UnitedHealthcare name may not be familiar to you, so we wanted to assure you that when you see references to UnitedHealthcare in this EOC, it has the same meaning as other materials you've seen which reflects that the PDP services are administered by Optum Rx®.

If you have any questions about the EOC or your PDP, please call Customer Service at **1-855-409-0219**, TTY **711**, 8 a.m.-8 p.m. local time, Monday-Friday.

2025 Evidence of Coverage Table of Contents

Chapter 1

Getting started as a member

Section 1 Introduction

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

You are covered by Original Medicare or another health plan for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, UAW Trust MedicareRx (PDP).

UAW Trust MedicareRx (PDP) 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 document about?

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

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

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

If you are confused, concerned or just have a question, please contact Customer Service.

Section 1.3 Legal information about the Evidence of Coverage

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

The contract is in effect for months in which you are enrolled in the plan between January 1, 2025 and December 31, 2025.

Each plan year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of the plan after December 31, 2025. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2025.

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

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

Section 2.1 Your eligibility requirements

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

- You meet the eligibility requirements of UAW Retiree Medical Benefits Trust (plan sponsor).
- You have Medicare Part A or Medicare Part B
- **— and —** You are a United States citizen or are lawfully present in the United States
- **— and —** You live in our geographic service area (Section 2.2 below describes our service area).

  Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Section 2.2 Here is the plan service area for UAW Trust MedicareRx (PDP)

Our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

The service area for this Plan includes the 50 United States, the District of Columbia and the U.S. Territories. Note: A member may only be enrolled in one Medicare Part D plan.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Retiree Health Care Connect (RHCC) at 1-866-636-7555 to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

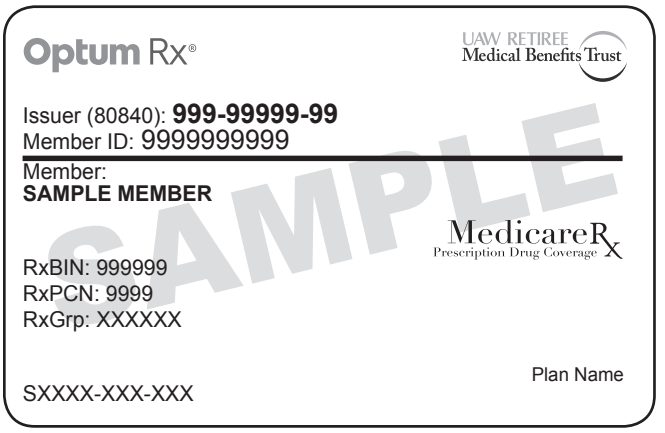
Section 2.3 U.S. Citizen or Lawful Presence

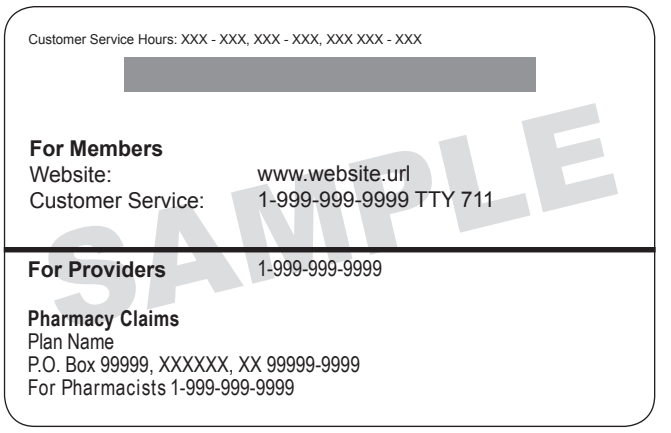
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UAW Trust MedicareRx (PDP) if you are not eligible to remain a member on this basis. UAW Trust MedicareRx (PDP) must disenroll you if you do not meet this requirement.

Section 3 Important membership materials you will receive

Section 3.1 Your member ID card

While you are a member of our plan, you must use your member ID card for prescription drugs you get at network pharmacies. Here's a sample member ID card to show you what yours will look like:





Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Section 3.2 Pharmacy Directory

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

If you don't have the **Pharmacy Directory**, you can get a copy from Customer Service. You can also find this information on our website at UAWTrustPDP.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 under the Part D benefit included in our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

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

The Drug List we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (UAWTrustPDP.com) or call Customer Service.

Section 4 Your monthly costs for the plan

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Income Related Monthly Adjusted Amount (Section 4.3)
- Medicare Prescription Payment Plan Amount (Section 4.4)

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

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

If you are **already enrolled** and getting help from one of these programs, the **information about premiums in this Evidence of Coverage may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider."

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2025 handbook, the section called "2025 Medicare Costs." If you need a copy you can download it from the Medicare website (medicare.gov/medicare-and-you). 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 4.1 Plan premium

Your coverage is provided through a contract with your current employer or former employer or union. UAW Retiree Medical Benefits Trust (plan sponsor) is responsible for paying your monthly plan premium to UnitedHealthcare on your behalf. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 4.3 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For

more information on the extra amount you may have to pay based on your income, visit medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.

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

Section 4.4 Medicare Prescription Payment Plan Amount

If you are participating in the Medicare Prescription Payment Plan, you'll get a bill from your drug plan for your Medicare-covered Part D prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any Part D prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 7 to make a complaint or appeal.

Section 5 Keeping your plan membership record up to date

Your membership record has information from your electronic election of our plan, 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.

Contact RHCC at 866-637-7555, Monday–Friday, 8:30 a.m.–4:30 p.m. ET to make name, address, or phone number changes.

Let UnitedHealthcare know about these changes:

- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Customer Service at 1-855-409-0219, TTY 711.

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

Section 6 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called Coordination of Benefits.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first (there may be some exceptions).
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

- Workers' Compensation

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

Chapter 2

Important phone numbers and resources

Section 1 UAW Trust MedicareRx (PDP) Contacts (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

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

Method	Customer Service - Contact Information
Call	**1-855-409-0219** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	**UAWTrustPDP.com**

How to contact us when you are asking for a coverage decision or appeal

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

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
Call	**1-855-409-0219** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	**711** Calls to this number are free.

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
	Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	Optum Rx Prior Authorization Department P.O. Box 25183, Santa Ana, CA 92799
Website	**UAWTrustPDP.com**

Method	Appeals for Part D Prescription Drugs – Contact Information
Call	**1-855-409-0219** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For fast/expedited appeals for Part D prescription drugs: **1-855-409-0219** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Fax	For standard Part D prescription drug appeals: **1-866-308-6294** For fast/expedited Part D prescription drug appeals: **1-866-308-6296**
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA120-0368, Cypress, CA 90630-0016
Website	**UAWTrustPDP.com**

How to contact us when you are making a complaint
You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint, 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	**1-855-409-0219** Calls to this number are free.

Method	Complaints about Part D Prescription Drugs – Contact Information
	Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For fast/expedited complaints about Part D prescription drugs: **1-855-409-0219** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Fax	For standard Part D prescription drug complaints: **1-866-308-6294** For fast/expedited Part D prescription drug complaints: **1-866-308-6296**
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA120-0368, Cypress, CA 90630-0016
Medicare Website	You can submit a complaint about UAW Trust MedicareRx (PDP) directly to Medicare. To submit an online complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx.**

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

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. If you have received a bill or paid for drugs (such as a pharmacy bill) that you think we should pay for, you may need to ask the plan for reimbursement or to pay the pharmacy bill. See Chapter 5 **(Asking us to pay our share of the costs for covered drugs)**.

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

Method	Payment Requests – Contact Information
Call	**1-855-409-0219** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	**711** Calls to this number are free.

Method	Payment Requests – Contact Information
	Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	Part D prescription drug payment requests: Optum Rx P.O. Box 650287, Dallas, TX 75265-0287
Website	**UAWTrustPDP.com**

Section 2 Medicare (how to get help and information directly from the federal Medicare program)

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Prescription Drug Plans, including us.

Method	Medicare – Contact Information
Call	**1-800-MEDICARE,** or **1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Website	**medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: □ **Medicare Eligibility Tool:** Provides Medicare eligibility status information. □ **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans,

Method	Medicare – Contact Information
	and Medigap (Medicare Supplement Insurance) policies in your area. Because your coverage is provided by a plan sponsor, you will not find UAW Trust MedicareRx (PDP) plans listed on medicare.gov. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about UAW Trust MedicareRx (PDP): □ **Tell Medicare about your complaint:** You can submit a complaint about UAW Trust MedicareRx (PDP) directly to Medicare. To submit a complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

- Alaska - Alaska Medicare Information Office
- Alabama - Alabama State Health Insurance Assistance Program (SHIP)
- Arkansas - Arkansas Senior Health Insurance Information Program (SHIIP)
- American Samoa - American Samoa Senior Health Insurance Program
- Arizona - Arizona State Health Insurance Assistance Program
- California - California Health Insurance Counseling & Advocacy Program (HICAP)
- Colorado - Colorado Senior Health Insurance Assistance Program (SHIP)
- Connecticut - Connecticut CHOICES Senior Health Insurance Program
- District of Columbia - Department of Aging and Community Living
- Delaware - Delaware Medicare Assistance Bureau (DMAB)
- Florida - Florida Serving Health Insurance Needs of Elders (SHINE)
- Georgia - GeorgiaCares Senior Health Insurance Plan
- Guam - Guam Medicare Assistance Program (GUAM MAP)
- Hawaii - Hawaii SHIP
- Iowa - Iowa Senior Health Insurance Information Program (SHIIP)
- Idaho - Idaho Senior Health Insurance Benefits Advisors (SHIBA)

- Illinois - Illinois Senior Health Insurance Program (SHIP)
- Indiana - Indiana State Health Insurance Assistance Program (SHIP)
- Kansas - Kansas Senior Health Insurance Counseling for Kansas (SHICK)
- Kentucky - Kentucky State Health Insurance Assistance Program (SHIP)
- Louisiana - Louisiana Senior Health Insurance Information Program (SHIIP)
- Massachusetts - Massachusetts Serving the Health Insurance Needs of Everyone (SHINE)
- Maryland - Maryland Department of Aging - Senior Health Insurance Assistance Program (SHIP)
- Maine - Maine State Health Insurance Assistance Program (SHIP)
- Minnesota - Minnesota State Health Insurance Assistance Program/Senior LinkAge Line
- Missouri - Missouri State Health Insurance Assistance Program
- Northern Mariana Islands - North Mariana Islands Senior Health Insurance Program
- Mississippi - Mississippi Department of Human Services, Division of Aging & Adult Services
- Montana - Montana State Health Insurance Assistance Program (SHIP)
- North Carolina - North Carolina Seniors Health Insurance Information Program (SHIIP)
- North Dakota - North Dakota Senior Health Insurance Counseling (SHIC)
- Nebraska - Nebraska Senior Health Insurance Information Program (SHIIP)
- New Hampshire - New Hampshire SHIP - ServiceLink Aging and Disability Resource Center
- New Jersey - New Jersey State Health Insurance Assistance Program (SHIP)
- New Mexico - New Mexico Benefits Counseling Program SHIP
- Nevada - Nevada State Health Insurance Assistance Program (SHIP)
- Ohio - Ohio Senior Health Insurance Information Program (OSHIIP)
- Oklahoma - Oklahoma Medicare Assistance Program (MAP)
- Oregon - Oregon Senior Health Insurance Benefits Assistance (SHIBA)
- Pennsylvania - PA MEDI
- Puerto Rico - Puerto Rico State Health Insurance Assistance Program (SHIP)
- Rhode Island - Rhode Island State Health Insurance Assistance Program (SHIP)
- South Carolina - South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders
- South Dakota - South Dakota Senior Health Information & Insurance Education (SHIINE)
- Tennessee - Tennessee Commission on Aging & Disability - TN SHIP
- Texas - Texas Department of Aging and Disability Services (HICAP)
- Utah - Utah Senior Health Insurance Information Program (SHIP)
- Virginia - Virginia Insurance Counseling and Assistance Program (VICAP)
- Virgin Islands of the U.S. - Virgin Islands State Health Insurance Assistance Program (VISHIP)
- Vermont - Vermont State Health Insurance Assistance Program (SHIP)
- Washington - Washington Statewide Health Insurance Benefits Advisors (SHIBA)
- Wisconsin - Wisconsin State Health Insurance Plan (SHIP)
- West Virginia - West Virginia State Health Insurance Assistance Program (WV SHIP)
- Wyoming - Wyoming State Health Insurance Information Program (WSHIIP)

Your SHIP is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

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

Method to access SHIP and other resources
□Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page) □Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Alaska | Alaska Medicare Information Office 550 W 7th Ave, STE1230 Anchorage, AK 99501 http://dhss.alaska.gov/dsds/Pages/medicare	1-800-478-6065 TTY 1-800-770-8973
Alabama | Alabama State Health Insurance Assistance Program (SHIP) 201 Monroe ST, STE 350 Montgomery, AL 36104 www.AlabamaAgeline.gov	1-877-425-2243 TTY 711
Arkansas | Arkansas Senior Health Insurance Information Program (SHIIP) 1 Commerce Way Little Rock, AR 72202 www.shiipar.com	1-800-224-6330 TTY 711
American Samoa | American Samoa Senior Health Insurance Program ASTCA Executive BLDG #306, P.O. Box 6101 Pago Pago, AS 96799 www.medicaid.as.gov	1-684-699-4777 TTY 711
Arizona | Arizona State Health Insurance Assistance Program 1366 E Thomas RD, STE 108 ATTN: SHIP Phoenix, AZ 85104 https://des.az.gov/services/older-adults/medicare-assistance	1-800-432-4040 TTY 711
California | California Health Insurance Counseling & Advocacy Program (HICAP) 2880 Gateway Oaks Dr, STE 200 Sacramento, CA 95833 http://www.aging.ca.gov/hicap/	1-800-434-0222 TTY 1-800-735-2929

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Colorado | Colorado Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, STE 850 Denver, CO 80202 https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare	1-888-696-7213 TTY 711
Connecticut | Connecticut CHOICES Senior Health Insurance Program 55 Farmington AVE, FL 12 Hartford, CT 06105-3730 https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/CHOICES-Connecticuts-program-for-Health-insurance-assistance-Outreach-Information-and-referral-Couns	1-800-994-9422 TTY 711
District of Columbia | Department of Aging and Community Living 500 K ST NE Washington, DC 20002 https://dcoa.dc.gov/	1-202-724-5626 TTY 711
Delaware | Delaware Medicare Assistance Bureau (DMAB) 1351 WN ST, STE 101 Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	1-800-336-9500 TTY 711
Florida | Florida Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, STE 270 Tallahassee, FL 32399-7000 www.floridashine.org	1-800-963-5337 TTY 1-800-955-8770
Georgia | GeorgiaCares Senior Health Insurance Plan 2 Peachtree ST NW, FL 33 Atlanta, GA 30303 https://aging.georgia.gov/georgiacares-ship	1-866-552-4464 TTY 711
Guam | Guam Medicare Assistance Program (GUAM MAP) 130 University DR, STE 8, University Castle Mall Mangilao, GU 96913 http://dphss.guam.gov/	1-671-735-7421 TTY 1-671-735-7415
Hawaii | Hawaii SHIP No. 1 Capitol District, 250 S Hotel ST, STE 406 Honolulu, HI 96813-2831 www.hawaiiship.org	1-888-875-9229 TTY 1-866-810-4379

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Iowa | Iowa Senior Health Insurance Information Program (SHIIP) 1963 Bell Avenue, STE 100 Des Moines, IA 50315 shiip.iowa.gov	1-800-351-4664 TTY 1-800-735-2942
Idaho | Idaho Senior Health Insurance Benefits Advisors (SHIBA) 700 W State St Boise, ID 83720 http://www.doi.idaho.gov/SHIBA/	1-800-247-4422 TTY 711
Illinois | Illinois Senior Health Insurance Program (SHIP) One Natural Resources Way, STE 100 Springfield, IL 62702-1271 http://www.illinois.gov/aging/ship/Pages/default.aspx	1-800-252-8966 TTY 711
Indiana | Indiana State Health Insurance Assistance Program (SHIP) 311 W Washington ST, STE 200 Indianapolis, IN 46204-2787 http://www.in.gov/ship	1-800-452-4800 TTY 1-866-846-0139
Kansas | Kansas Senior Health Insurance Counseling for Kansas (SHICK) New England BLDG, 503 S Kansas AVE Topeka, KS 66603-3404 https://www.kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick	1-800-860-5260 TTY 1-785-291-3167
Kentucky | Kentucky State Health Insurance Assistance Program (SHIP) 275 E Main ST, 3E-E Frankfort, KY 40621 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	1-877-293-7447 TTY 1-800-627-4702
Louisiana | Louisiana Senior Health Insurance Information Program (SHIIP) P.O. Box 94214 Baton Rouge, LA 70804 http://www.ldi.la.gov/SHIIP/	1-800-259-5300 TTY 711
Massachusetts | Massachusetts Serving the Health Insurance Needs of Everyone (SHINE) 1 Ashburton PL, RM 517 Boston, MA 02108 http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html	1-800-243-4636 TTY 1-800-439-2370

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Maryland | Maryland Department of Aging - Senior Health Insurance Assistance Program (SHIP) 301 W Preston ST, STE 1007 Baltimore, MD 21201 https://aging.maryland.gov/Pages/state-health-insurance-program.aspx	1-800-243-3425 TTY 711
Maine | Maine State Health Insurance Assistance Program (SHIP) 11 State House Station, 41 Anthony AVE Augusta, ME 04333 https://www.maine.gov/dhhs/oads/community-support/ship.html	1-800-262-2232 TTY 711
Minnesota | Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar Street St. Paul, MN 55164-0976 https://mn.gov/senior-linkage-line	1-800-333-2433 TTY 1-800-627-3529
Missouri | Missouri State Health Insurance Assistance Program 601 W Nifong Blvd, STE 3A Columbia, MO 65203 https://www.missouriship.org	1-800-390-3330 TTY 711
Northern Mariana Islands | North Mariana Islands Senior Health Insurance Program P.O. Box 5795 CHRB Saipan, MP 96950 http://commerce.gov.mp/	1-670-664-3000 TTY 711
Mississippi | Mississippi Department of Human Services, Division of Aging & Adult Services 200 S Lamar ST Jackson, MS 39201 http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/	1-601-359-4500 TTY 711
Montana | Montana State Health Insurance Assistance Program (SHIP) 1100 N Last Chance Gulch, FL 4 Helena, MT 59601 http://dphhs.mt.gov/sltc/aging/ship	1-800-551-3191 TTY 711
North Carolina | North Carolina Seniors Health Insurance Information Program (SHIIP) 325 N Salisbury ST Raleigh, NC 27603 http://www.ncdoi.com/SHIIP	1-855-408-1212 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
North Dakota | North Dakota Senior Health Insurance Counseling (SHIC) 600 E BLVD AVE Bismarck, ND 58505-0320 https://www.insurance.nd.gov/consumers/shic-medicare	1-888-575-6611 TTY 1-800-366-6888
Nebraska | Nebraska Senior Health Insurance Information Program (SHIIP) 2717 S. 8th Street, STE 4 Lincoln, NE 68508 https://doi.nebraska.gov/consumer/senior-health	1-800-234-7119 TTY 711
New Hampshire | New Hampshire SHIP - ServiceLink Aging and Disability Resource Center 25 Roxbury St, STE 106 Keene, NH 03431 https://www.servicelink.nh.gov	1-866-634-9412 TTY 1-800-735-2964
New Jersey | New Jersey State Health Insurance Assistance Program (SHIP) P.O. Box 715 Trenton, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/services/ship/index.html	1-800-792-8820 TTY 711
New Mexico | New Mexico Benefits Counseling Program SHIP 2250 Cerrillos Rd Santa Fe, NM 87505 www.nmaging.state.nm.us	1-800-432-2080 TTY 1-505-476-4937
Nevada | Nevada State Health Insurance Assistance Program (SHIP) 3416 Goni RD, STE D-132 Carson City, NV 89706 http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/	1-800-307-4444 TTY 711
Ohio | Ohio Senior Health Insurance Information Program (OSHIIP) 50 W Town ST, STE 300, FL 3 Columbus, OH 43215 https://insurance.ohio.gov/wps/portal/gov/odi/consumers	1-800-686-1578 TTY 1-614-644-3745
Oklahoma | Oklahoma Medicare Assistance Program (MAP) 400 NE 50th ST Oklahoma City, OK 73105 www.map.oid.ok.gov	1-800-763-2828 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Oregon | Oregon Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter St NE Salem, OR 97309 oregonshiba.org	1-800-722-4134 TTY 711
Pennsylvania | PA MEDI 555 Walnut ST, FL 5 Harrisburg, PA 17101-1919 aging.pa.gov	1-800-783-7067 TTY 711
Puerto Rico | Puerto Rico State Health Insurance Assistance Program (SHIP) Ponce de León AVE, PDA 16, EDIF 1064, 3er nivel San Juan, PR 00919-1179 www.oppea.pr.gov	1-787-721-6121 TTY 711
Rhode Island | Rhode Island State Health Insurance Assistance Program (SHIP) 25 Howard AVE, BLDG 57 Cranston, RI 02920 https://oha.ri.gov/	1-401-462-3000 TTY 1-401-462-0740
South Carolina | South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais ST, STE 350 Columbia, SC 29201 https://aging.sc.gov/	1-800-868-9095 TTY 711
South Dakota | South Dakota Senior Health Information & Insurance Education (SHIINE) 2520 E Franklin St Pierre, SD 57501 www.shiine.net	1-877-331-4834 TTY 711
Tennessee | Tennessee Commission on Aging & Disability - TN SHIP Andrew Jackson BLDG, 502 Deaderick ST, FL 9 Nashville, TN 37243-0860 https://www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html	1-877-801-0044 TTY 711
Texas | Texas Department of Aging and Disability Services (HICAP) P.O. Box 13247 Austin, TX 78711 https://hhs.texas.gov/services/health/medicare	1-800-252-9240 TTY 1-512-424-6597

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Utah | Utah Senior Health Insurance Information Program (SHIP) 195 N 1950 W Salt Lake City, UT 84116 https://daas.utah.gov	1-800-541-7735 TTY 711
Virginia | Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest AVE, STE 100 Henrico, VA 23229 https://www.vda.virginia.gov/vicap.htm	1-800-552-3402 TTY 711
Virgin Islands of the U.S. | Virgin Islands State Health Insurance Assistance Program (VISHIP) 1131 King ST, STE 101 St. Croix, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	1-340-773-6449 TTY 711
Vermont | Vermont State Health Insurance Assistance Program (SHIP) P.O. Box 321 Jericho, VT 05465 www.vermont4a.org	1-800-642-5119 TTY 711
Washington | Washington Statewide Health Insurance Benefits Advisors (SHIBA) P.O. Box 40255 Olympia, WA 98504-0255 www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba	1-800-562-6900 TTY 1-360-586-0241
Wisconsin | Wisconsin State Health Insurance Plan (SHIP) 1402 Pankratz ST, STE 111 Madison, WI 53704 www.longtermcare.wi.gov	1-800-242-1060 TTY 711
West Virginia | West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha BLVD E Charleston, WV 25305 www.wvship.org	1-877-987-4463 TTY 711
Wyoming | Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams AVE Riverton, WY 82501 www.wyomingseniors.com	1-800-856-4398 TTY 711

Section 4 Quality Improvement Organization

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

- Alaska - ACENTRA
- Alabama - ACENTRA
- Arkansas - ACENTRA
- American Samoa - Livanta BFCC-QIO Program
- Arizona - Livanta BFCC-QIO Program
- California - Livanta BFCC-QIO Program
- Colorado - ACENTRA
- Connecticut - ACENTRA
- District of Columbia - Livanta BFCC-QIO Program
- Delaware - Livanta BFCC-QIO Program
- Florida - ACENTRA
- Georgia - ACENTRA
- Guam - Livanta BFCC-QIO Program
- Hawaii - Livanta BFCC-QIO Program
- Iowa - Livanta BFCC-QIO Program
- Idaho - ACENTRA
- Illinois - Livanta BFCC-QIO Program
- Indiana - Livanta BFCC-QIO Program
- Kansas - Livanta BFCC-QIO Program
- Kentucky - ACENTRA
- Louisiana - ACENTRA
- Massachusetts - ACENTRA
- Maryland - Livanta BFCC-QIO Program
- Maine - ACENTRA
- Minnesota - Livanta BFCC-QIO Program
- Missouri - Livanta BFCC-QIO Program
- Northern Mariana Islands - Livanta BFCC-QIO Program
- Mississippi - ACENTRA
- Montana - ACENTRA
- North Carolina - ACENTRA
- North Dakota - ACENTRA
- Nebraska - Livanta BFCC-QIO Program
- New Hampshire - ACENTRA
- New Jersey - Livanta BFCC-QIO Program
- New Mexico - ACENTRA
- Nevada - Livanta BFCC-QIO Program
- Ohio - Livanta BFCC-QIO Program
- Oklahoma - ACENTRA
- Oregon - ACENTRA
- Pennsylvania - Livanta BFCC-QIO Program

- Puerto Rico - Livanta BFCC-QIO Program
- Rhode Island - ACENTRA
- South Carolina - ACENTRA
- South Dakota - ACENTRA
- Tennessee - ACENTRA
- Texas - ACENTRA
- U.S. Minor Outlying Islands - ACENTRA
- Utah - ACENTRA
- Virginia - Livanta BFCC-QIO Program
- Virgin Islands of the U.S. - Livanta BFCC-QIO Program
- Vermont - ACENTRA
- Washington - ACENTRA
- Wisconsin - Livanta BFCC-QIO Program
- West Virginia - Livanta BFCC-QIO Program
- Wyoming - ACENTRA

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

You should contact your state's Quality Improvement Organization 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.

Quality Improvement Organization (QIO) – Contact Information	
Alaska | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-305-6759 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Alabama | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Arkansas | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
American Samoa | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668
Arizona | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
California | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Colorado | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Connecticut | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
District of Columbia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Delaware | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Florida | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Georgia | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Guam | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Hawaii | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Iowa | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 TTY 1-888-985-9295 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Idaho | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-305-6759 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Illinois | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Indiana | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Kansas | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 TTY 1-888-985-9295 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Kentucky | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Louisiana | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Massachusetts | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Maryland | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Maine | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Minnesota | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Missouri | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 TTY 1-888-985-9295 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Northern Mariana Islands | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668
Mississippi | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Montana | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
North Carolina | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
North Dakota | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Nebraska | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 TTY 1-888-985-9295 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
New Hampshire | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
New Jersey | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-866-815-5440 TTY 1-866-868-2289 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
New Mexico | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Nevada | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Ohio | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Oklahoma | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Oregon | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-305-6759 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Pennsylvania | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Puerto Rico | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-787-520-5743 TTY 1-866-868-2289 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Rhode Island | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
South Carolina | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
South Dakota | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Tennessee | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Texas | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
U.S. Minor Outlying Islands | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0891 TTY 711
Utah | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Virginia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Virgin Islands of the U.S. | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-340-773-6334 TTY 1-866-868-2289
Vermont | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Washington | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-305-6759 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Wisconsin | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
West Virginia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
Wyoming | ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays

Section 5 Social Security

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

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

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

Method	Social Security – Contact Information
Call	**1-800-772-1213** Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
Website	**ssa.gov**

Section 6 Medicaid

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

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

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

To find out more about Medicaid and its programs, contact your state Medicaid agency.

State Medicaid Programs – Contact Information	
Alaska | State of Alaska Department of Health & Social Services, Division of Health Care Services 855 W.Commercial Drive, STE 131 Anchorage, AK 99654 http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx	1-800-478-7778 TTY 711
Alabama | Alabama Medicaid P.O. Box 5624 Montgomery, AL 36103-5624 http://www.medicaid.alabama.gov/	1-800-362-1504 TTY 1-800-253-0799
Arkansas | Arkansas Division of Medical Services Department of Human Services Donaghey Plaza S, P.O. Box 1437 Slot S401 Little Rock, AR 72203-1437 https://humanservices.arkansas.gov/divisions-shared-services/medical-services/	1-800-482-8988 TTY 1-800-285-1131
American Samoa | American Samoa Medicaid State Agency ASCTA Executive BLDG #306, P.O. Box 6101 Pago Pago, AS 96799 http://medicaid.as.gov/	1-684-699-4777 TTY 711
Arizona | Arizona Health Care Cost Containment System (AHCCCS) 801 E Jefferson ST Phoenix, AZ 85034 www.azahcccs.gov	1-855-432-7587 TTY 1-800-367-8939
Arizona | Arizona Department of Economic Security / Division of Developmental Disabilities (DDD) 1789 W Jefferson ST Phoenix, AZ 85007 https://des.az.gov/services/disabilities/developmental-disabilities	1-844-770-9500 TTY 711
California | Medi-Cal - Managed Care Operations Division Department of Health Care Services P.O. Box 989009 West Sacramento, CA 95798-9850 https://www.healthcareoptions.dhcs.ca.gov/	1-800-430-4263 TTY 1-800-430-7077
Colorado | Colorado Department of Health Care Policy and Financing 1570 Grant ST Denver, CO 80203-1818 www.healthfirstcolorado.com	1-800-221-3943 TTY 711

State Medicaid Programs – Contact Information	
Connecticut | Connecticut State Medicaid 55 Farmington AVE Hartford, CT 06105-3730 portal.ct.gov/husky	1-877-284-8759 TTY 1-866-492-5276
District of Columbia | DC Department of Human Services 64 New York AVE NE, FL 6 Washington, DC 20002 https://dhs.dc.gov/service/medical-assistance	1-202-671-4200 TTY 711
Delaware | Delaware Health and Social Services 1901 N Dupont HWY, Lewis BLDG New Castle, DE 19720 http://dhss.delaware.gov/dhss/	1-302-255-9040 TTY 711
Florida | Florida Medicaid Agency for Health Care Administration (AHCA) 2727 Mahan DR, MS 6 Tallahassee, FL 32308 https://ahca.myflorida.com/	1-888-419-3456 TTY 1-800-955-8771
Georgia | Georgia Department of Community Health 1249 Donald Lee Hollowell Parkway Atlanta, GA 30318 https://medicaid.georgia.gov/	1-877-423-4746 TTY 711
Guam | Guam Department of Public Health and Social Services Bureau of Health Care Financing 123 Chalan Kareta Mangilao, GU 96913-6304 http://www.dphss.guam.gov/	1-671-735-7243 TTY 711
Hawaii | Department of Human Services 1390 Miller ST, RM 209 Honolulu, HI 96813 https://humanservices.hawaii.gov/	1-808-586-5390 TTY 711
Iowa | Department of Human Services (Iowa Medicaid Enterprise) 1305 E Walnut Street FL 5 Des Moines, IA 50319 http://dhs.iowa.gov/	1-800-338-8366 TTY 1-800-735-2942
Idaho | Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720-0026 https://healthandwelfare.idaho.gov	1-877-456-1233 TTY 1-888-791-3004
Illinois | Illinois Department of Healthcare and Family Services 100 S Grand AVE E Springfield, IL 62704 http://www2.illinois.gov/hfs/	1-800-843-6154 TTY 1-800-447-6404

State Medicaid Programs – Contact Information	
Indiana | Louisiana Department of Health 628 N 4th Street Baton Rouge, LA 70802 https://ldh.la.gov/	1-225-342-9500 TTY 711
Kansas | Kansas Dept. of Health and Environment 900 SW Jackson ST Topeka, KS 66612 http://www.kancare.ks.gov/	1-800-792-4884 TTY 711
Kentucky | Kentucky Cabinet for Health and Family Services 275 E Main ST Frankfort, KY 40621 https://chfs.ky.gov/	1-800-635-2570 TTY 711
Louisiana | Louisiana Department of Health 628 N 4th Street Baton Rouge, LA 70802 https://ldh.la.gov/	1-225-342-9500 TTY 711
Massachusetts | Executive Office of Health and Human Services 100 Hancock ST, FL 6 Quincy, MA 02171 http://www.mass.gov/eohhs/gov/departments/masshealth/	1-800-841-2900 TTY 1-800-497-4648
Maryland | Maryland Department of Health 201 W Preston ST Baltimore, MD 21201-2399 https://health.maryland.gov/pages/index.aspx	1-877-463-3464 TTY 1-800-735-2258
Maine | Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms/	1-800-977-6740 TTY 711
Minnesota | Minnesota Department of Human Services P.O. Box 64989 St. Paul, MN 55164-0989 http://mn.gov/dhs	1-800-657-3739 TTY 1-800-627-3529
Missouri | MO HealthNet Division Department of Social Services 615 Howerton CT, P.O. Box 6500 Jefferson City, MO 65102-6500 https://www.dss.mo.gov/mhd/	1-573-526-4274 TTY 1-800-735-2966

State Medicaid Programs – Contact Information	
Northern Mariana Islands | State Medicaid Administration Office Government BLDG # 1252, Capital Hill RD, Caller Box 100007 Saipan, MP 96950 http://medicaid.cnmi.mp/	1-670-664-4880 TTY 711
Mississippi | State of Mississippi Division of Medicaid 550 High ST STE, 1000 Sillers BLDG Jackson, MS 39201-1399 http://www.medicaid.ms.gov/	1-800-421-2408 TTY 711
Montana | Montana Healthcare Programs P.O. Box 202951 Helena, MT 59620-2951 https://dphhs.mt.gov/MontanaHealthcarePrograms	1-888-362-8312 TTY 1-800-833-8503
North Carolina | North Carolina Department of Health and Human Services 2501 Mail Service CTR Raleigh, NC 27699-2501 https://dma.ncdhhs.gov/medicaid	1-888-245-0179 TTY 1-877-452-2514
North Dakota | North Dakota Department of Human Services 600 E. Boulevard Ave., Dept. 325 Bismarck, ND 58505-0250 https://www.hhs.nd.gov/healthcare/medicaid	1-866-614-6005 TTY 711
Nebraska | Nebraska Department of Health and Human Services 301 Centennial Mall S Lincoln, NE 68509 http://dhhs.ne.gov/Pages/default.aspx	1-402-471-3121 TTY 1-800-471-7352
New Hampshire | New Hampshire Department of Health and Human Services 129 Pleasant ST Concord, NH 03301-3852 https://www.dhhs.nh.gov/ombp/medicaid/	1-844-275-3447 TTY 1-800-735-2964
New Jersey | Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625-0712 https://www.state.nj.us/humanservices/dmahs/	1-800-701-0710 TTY 711
New Mexico | NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504-2348 https://www.hsd.state.nm.us/	1-888-997-2583 TTY 1-855-227-5485

State Medicaid Programs – Contact Information	
Nevada | Nevada Department of Health and Human Services 1100 E Williams ST, STE 101 Carson City, NV 89701 http://dhcfp.nv.gov	1-800-992-0900 TTY 711
Ohio | Ohio Department of Medicaid 50 W Town ST, STE 400 Columbus, OH 43215 https://medicaid.ohio.gov/	1-800-324-8680 TTY 711
Oklahoma | Oklahoma Health Care Authority 4345 N Lincoln BLVD Oklahoma City, OK 73105 http://www.okhca.org	1-800-987-7767 TTY 711
Oregon | Oregon Health Authority 500 Summer ST, NE, E-20 Salem, OR 97301-1097 https://www.oregon.gov/oha/HSD/OHP	1-503-947-2340 TTY 711
Pennsylvania | Pennsylvania Department of Human Services P.O. Box 5959 Harrisburg, PA 17110-0959 http://www.dhs.pa.gov/	1-800-692-7462 TTY 1-800-451-5886
Puerto Rico | Government of Puerto Rico, Department of Health Medicaid Program P.O. Box 70184 San Juan, PR 00936-8184 https://medicaid.pr.gov	1-787-765-2929 TTY 1-787-625-6955
Rhode Island | Executive Office of Health and Human Services (EOHHS) 3 West Road Cranston, RI 02920 http://www.eohhs.ri.gov/	1-401-462-5274 TTY 711
South Carolina | South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206 http://www.scdhhs.gov/	1-888-549-0820 TTY 1-888-842-3620
South Dakota | South Dakota Department of Social Services, Division of Medical Services 700 Governors DR Pierre, SD 57501 http://dss.sd.gov/medicaid/	1-800-597-1603 TTY 711

State Medicaid Programs – Contact Information	
Tennessee | Division of TennCare 310 Great Circle RD Nashville, TN 37243 https://www.tn.gov/tenncare/	1-800-342-3145 TTY 711
Texas | Texas Medicaid Health and Human Services Commission 4900 N Lamar BLVD, P.O. Box 13247 Austin, TX 78751 https://hhs.texas.gov/about-hhs/find-us	1-512-424-6500 TTY 1-512-424-6597
Utah | Utah Department of Health, Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 https://medicaid.utah.gov/	1-800-662-9651 TTY 711
Virginia | Virginia Department of Medical Assistance Services 600 E Broad ST Richmond, VA 23219 http://www.dmas.virginia.gov/	1-855-242-8282 TTY 711
Virgin Islands of the U.S. | U.S. Virgin Islands Bureau of Health Insurance & Medical Assistance 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 www.dhs.gov.vi	1-340-715-6929 TTY 711
Vermont | Department of Vermont Health Access 280 ST DR Waterbury, VT 05671 http://www.greenmountaincare.org/	1-800-250-8427 TTY 711
Washington | Apple Health P.O. Box 45531 Olympia, WA 98501 hca.wa.gov	1-800-562-3022 TTY 711
Wisconsin | Wisconsin Department of Health Services 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/health-care-coverage/index.htm	1-800-362-3002 TTY 711
West Virginia | West Virginia Bureau for Medical Services 350 Capitol ST, RM 251 Charleston, WV 25301 http://www.dhhr.wv.gov/bms/Pages/default.aspx	1-304-558-1700 TTY 711

State Medicaid Programs – Contact Information	
Wyoming | Wyoming Department of Health 122 W 25th St., 4th FL West Cheyenne, WY 82001 http://health.wyo.gov/healthcarefin/medicaid/	1-307-777-7531 TTY 1-855-329-5205

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

The Medicare.gov website (medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

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

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

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)? What is the AIDS Drug Assistance Program (ADAP)?

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

If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP office listed below.

AIDS Drug Assistance Program (ADAP) – Contact Information	
Alaska | Alaskan AIDS Assistance Association 1057 W Fireweed LN, STE 102 Anchorage, AK 99503 http://www.alaskanaids.org/index.php/client-services/adap	1-800-478-2437 9 a.m.-5 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Alabama | Alabama AIDS Drug Assistance Program Office of HIV Prevention and Care, 201 Monroe ST, STE 1400 Montgomery, AL 36104 http://www.alabamapublichealth.gov/hiv/adap.html	1-866-574-9964 8 a.m.-5 p.m. local time, Monday-Friday
Arkansas | Arkansas Department of Health, Ryan White Program - Part B 4815 W Markham ST, Slot 33 Little Rock, AR 72205 https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-faqs	1-501-661-2408 8 a.m. - 4:30 p.m. local time, Monday - Friday
American Samoa | American Samoa Department of Health Faagaalu RD 1 Pago Pago, AS 96799 https://www.americansamoa.gov/departments	1-684-633-1433 8 a.m.-5 p.m. local time, Monday-Friday
Arizona | Arizona Department of Health Services ADAP 150 N 18th AVE, STE 110 Phoenix, AZ 85007 https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home	1-800-334-1540 8 a.m.-5 p.m. local time, Monday-Friday
California | Department of Health Services - ADAP P.O. Box 997426, MS 7704 Sacramento, CA 95899-7426 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_medpartd.aspx	1-844-421-7050 8 a.m. - 5 p.m. local time, Monday - Friday
Colorado | Colorado State Drug Assistance Program (SDAP) ADAP-3800, 4300 Cherry Creek DR S Denver, CO 80246-1530 https://cdphe.colorado.gov/state-drug-assistance-program	1-303-692-2716 9 a.m.-5 p.m. local time, Monday-Friday
Connecticut | Connecticut ADAP Magellan Health Services P.O. Box 9971 Glen Allen, VA 23060 https://ctdph.magellanrx.com	1-800-424-3310 8 a.m.-4 p.m. local time, Monday-Friday
District of Columbia | District of Columbia ADAP AIDS Drug Assistance Program (ADAP) 899 N Capitol ST NE Washington, DC 20002 https://dchealth.dc.gov/node/137072	1-202-671-4815 8:15 a.m. - 4:45 p.m. local time, Monday - Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Delaware | Delaware Division of Public Health Ryan White Program 540 S DuPont HWY Dover, DE 19901 http://www.dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html	1-302-744-1050 8 a.m.-4:30 p.m. local time, Monday-Friday
Florida | Florida Department of Health ADAP HIV/AIDS Section, 4052 Bald Cypress Way Tallahassee, FL 32399 http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	1-800-352-2437 8 a.m.-9 p.m. local time, Monday-Friday
Georgia | Georgia AIDS Drug Assistance Program (ADAP) 200 Piedmont Ave., SE Atlanta, GA 30303-3186 https://dph.georgia.gov/health-topics/office-hivaids/hiv-care/aids-drug-assistance-program-adap	1-404-656-9805 8 a.m.-5 p.m. local time, Monday-Friday
Guam | Bureau of Communicable Disease Control - STD/HIV/ Viral Hepatitis Program 520 West Santa Monica Avenue, RM 126 Dededo, GU 96913 http://www.dphss.guam.gov/document/ryan-white-hivaids-program-brochure	1-671-735-3603 8 a.m.-5 p.m. local time, Monday-Friday
Hawaii | Hawaii State Department of Health Harm Reduction Services Branch 3627 Kilauea AVE, STE 306 Honolulu, HI 96816 https://health.hawaii.gov/harmreduction/	1-808-733-9360 7:45 a.m. - 4:30 p.m. local time, Monday - Friday
Iowa | Iowa AIDS Drug Assistance Program (ADAP) 321 E 12th ST Des Moines, IA 50319-0075 https://www.idph.iowa.gov/hivstdhep/hiv/support	1-515-204-3746 8 a.m.-4:30 p.m. local time, Monday-Friday
Idaho | Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, FL 4 Boise, ID 83720-0036 https://www.idph.iowa.gov/hivstdhep/hiv/support	1-208-334-5612 8 a.m.-5 p.m. local time, Monday-Friday
Illinois | Illinois ADAP 525 W Jefferson ST, FL 1 Springfield, IL 62761 https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services	1-800-825-3518 8:30 a.m.-4:00 p.m. local time, Monday-Friday
Indiana | Indiana HIV Medical Services Program 2 N Meridian ST, STE 6C Indianapolis, IN 46206 https://www.in.gov/health/hiv-std-viral-hepatitis/	1-866-588-4948 8 a.m.-5 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Kansas | Kansas AIDS Drug Assistance Program 1000 SW Jackson ST, STE 210 Topeka, KS 66612 https://www.kdhe.ks.gov/355/Ryan-White-Part-B-Program	1-785-296-6174
Kentucky | Kentucky AIDS Drug Assistance Program (KADAP) HIV/AIDS Branch, 275 E Main ST, HS2E-C Frankfort, KY 40621 https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	1-502-564-6539 8 a.m.-4:30 p.m. local time, Monday-Friday
Louisiana | Louisiana Office of Public Health STD/HIV Program, 1450 Poydras ST, STE 2136 New Orleans, LA 70112 http://new.dhh.louisiana.gov/index.cfm/page/1099	1-504-568-7474 8 a.m.-5 p.m. local time, Monday-Friday
Massachusetts | AccessHealth MA ATTN: HDAP The Schrafft's City CTR, 529 Main ST, STE 301 Charlestown, MA 02129 https://accesshealthma.org/drug-assistance/hdap/	1-617-502-1700 8 a.m.-5 p.m. local time, Monday-Friday
Maryland | Maryland AIDS Drug Assistance Program Client Services, 1223 W. Pratt ST Baltimore, MD 21223 https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx	1-410-767-6536 8:30 a.m.-4:30 p.m. local time, Monday-Friday
Maine | Maine AIDS Drug Assistance Program 11 State House Station, 286 Water ST Augusta, ME 04330 http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/aids-drug-assist.shtml	1-207-287-3747 8 a.m.-5 p.m. local time, Monday-Friday
Minnesota | Minnesota HIV Programs Department of Human Services, P.O. Box 64972 St. Paul, MN 55164-0972 http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/contact-us/index.jsp	1-800-657-3761 9 a.m. - 5 p.m. local time, Monday - Friday
Missouri | Missouri Bureau of HIV, STD and Hepatitis Department of Health and Senior Services, P.O. Box 570 Jefferson City, MO 65102-0570 https://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php	1-573-751-6439 8 a.m.-5 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Mississippi | Mississippi Department of Health, STD/HIV Office 570 E Woodrow Wilson DR, P.O. Box 1700 Jackson, MS 39215-1700 http://msdh.ms.gov/msdhsite/_static/14,0,150.html	1-601-576-7723 8 a.m.-5 p.m. local time, Monday-Friday
Montana | Montana AIDS Drug Assistance Program (ADAP) DPHHS, Cogswell BLDG C-211, 1400 Broadway ST Helena, MT 59620-2951 https://dphhs.mt.gov/publichealth/hivstd/Treatment/mtryanwhiteprog	1-406-444-3565 8 a.m.-5 p.m. local time, Monday-Friday
North Carolina | North Carolina HIV Medication Assistance Program N.C. Dept. of Health and Human Services, 2001 Mail Service Center Raleigh, NC 27699-2000 https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html	1-919-733-3419 8 a.m.-5 p.m. local time, Monday-Friday
North Dakota | North Dakota Department of Health, Division of Disease Control 2635 E Main AVE, P.O. Box 5520 Bismarck, ND 58506-5520 http://www.ndhealth.gov/hiv/contact/	1-800-472-2180 8 a.m.-5 p.m. local time, Monday-Friday
Nebraska | Nebraska Department of Health & Human Services Ryan White HIV/AIDS Program, P.O. Box 95026 Lincoln, NE 68509-5026 http://dhhs.ne.gov/Pages/Ryan-White.aspx	1-402-471-2101 8 a.m.-5 p.m. local time, Monday-Friday
New Hampshire | New Hampshire CARE Program 129 Pleasant ST Concord, NH 03301 https://www.dhhs.nh.gov/dphs/bchs/std/care.htm	1-800-852-3345 8 a.m.-4:30 p.m. local time, Monday-Friday
New Jersey | New Jersey AIDS Drug Distribution Program (ADDP) P.O. Box 360 Trenton, NJ 08625-0360 http://www.state.nj.us/health/hivstdtb/hiv-aids/medications.shtml	1-877-613-4533 8 a.m.-4:30 p.m. local time, Monday-Friday
New Mexico | New Mexico Department of Health , AIDS Drug Assistance Program 1190 S Saint Francis DR, STE 1200 Santa Fe, NM 87505 http://nmhealth.org/about/phd/idb/hats/	1-505-827-2435 8 a.m.-5 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Nevada | Nevada Office of HIV/AIDS 4126 Technology Way, STE 200 Carson City, NV 89706 http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/	1-775-684-3499 8 a.m.-5 p.m. local time, Monday-Friday
Ohio | Ohio HIV Drug Assistance Program (OHDAP) Ohio Department of Health 246 N High ST Columbus, OH 43215 https://odh.ohio.gov/know-our-programs/ryan-white-part-b-hiv-client-services/aids-drug-assistance-program	1-800-777-4775 8 a.m.-5 p.m. local time, Monday-Friday
Oklahoma | Oklahoma AIDS Coordination & Information Services Oklahoma Department of Health, 2400 N. Lincoln BLVD Oklahoma City, OK 73111 https://oklahoma.gov/okdhs/services/health/aids-coordination-and-information-services.html	1-405-271-5816 8 a.m.-5 p.m. local time, Monday-Friday
Oregon | Oregon CAREAssist 800 NE Oregon ST, STE 1105 Portland, OR 97232 http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx	1-971-673-0144 8 a.m.-5 p.m. local time, Monday-Friday
Pennsylvania | Pennsylvania Special Pharmaceutical Benefits Program Department of Health PO Box 8808 Harrisburg, PA 17120 https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx	1-800-922-9384 8 a.m.-4:30 p.m. local time, Monday-Friday
Puerto Rico | Puerto Rico Departmento de Salud, Programa Ryan White Parte B P.O. Box 70184 San Juan, PR 00936-8184 http://www.salud.gov.pr/Dept-de-Salud/Pages/Directorio.aspx	1-787-765-2929 8 a.m.-4:30 p.m. local time, Monday-Friday
Rhode Island | Rhode Island AIDS Drug Assistance Program Executive Office of Health & Human Services 3 West RD Cranston, RI 02920 https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx	1-401-222-5960 8:30 a.m.-4:30 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
South Carolina | South Carolina AIDS Drug Assistance Program (ADAP) DHEC, STD/HIV Division, 2600 Bull ST Columbia, SC 29201 http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/	1-800-856-9954 8 a.m.-5 p.m. local time, Monday-Friday
South Dakota | Ryan White Part B CARE Program South Dakota Department of Health, 615 E 4th ST Pierre, SD 57501-1700 https://doh.sd.gov/diseases/infectious/ryanwhite/	1-800-592-1861 8 a.m.-5 p.m. local time, Monday-Friday
Tennessee | Ryan White Part B Program Department of Health, 710 James Robertson PKWY Nashville, TN 37243 https://www.tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program/-tennessee-ryan-white-part-b-programs.html	1-615-741-7500 8 a.m.-4:30 p.m. local time, Monday-Friday
Texas | Texas HIV Medication Program ATTN: MSJA, MC 1873, P.O. Box 149347 Austin, TX 78714-9387 www.dshs.state.tx.us/hivstd/meds	1-800-255-1090 8 a.m.-5 p.m. local time, Monday-Friday
Utah | Utah Department of Health, Bureau of Epidemiology 288 N 1460 W, P.O. Box 142104 Salt Lake City, UT 84114-2104 http://health.utah.gov/epi/treatment/	1-801-538-6191 8 a.m.-5 p.m. local time, Monday-Friday
Virginia | Virginia Medication Assistance Program (MAP) 109 Governor ST Richmond, VA 23219 https://www.vdh.virginia.gov/disease-prevention/vamap/	1-800-533-4148 8 a.m.-5 p.m. local time, Monday-Friday
Virgin Islands of the U.S. | US Virgin Islands STD/HIV/TB Program USVI Department of Health, Old Municipal Hospital Complex, BLDG 1 St. Thomas, VI 00802 https://doh.vi.gov/programs/communicable-diseases	1-340-774-9000
Vermont | VT Medication Assistance Program Health Surveillance Division, P.O. Box 70 Burlington, VT 05402 http://healthvermont.gov/prevent/aids/aids_index.aspx	1-802-863-7240 7:45 a.m.-4:30 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Washington | Washington Early Intervention Program (EIP) Client Services, P.O. Box 47841 Olympia, WA 98504-7841 https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP	1-877-376-9316 8 a.m.-5 p.m. local time, Monday-Friday
Wisconsin | Wisconsin AIDS Drug Assistance Program (ADAP) Department of Health Services, 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/hiv/adap-consumer-client.htm	1-800-991-5532 8 a.m.-5 p.m. local time, Monday-Friday
West Virginia | West Virginia AIDS Drug Assistance Program (ADAP) 350 Capitol ST, RM 125 Charleston, WV 25301 https://oeps.wv.gov/aboutus/Pages/about_dsh.aspx	1-800-642-8244 8 a.m.-4 p.m. local time, Monday-Friday
Wyoming | Wyoming Department of Health Communicable Disease Unit HIV Treatment Program, 401 Hathaway BLDG Cheyenne, WY 82002 https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/	1-307-777-7529 8 a.m.-5 p.m. local time, Monday-Friday

State Pharmaceutical Assistance Programs

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

Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:

- California - Department of Health Services - ADAP
- Colorado - Colorado Department of Health Care Policy & Financing
- Connecticut - Connecticut AIDS Drug Assistance Program (CADAP)
- District of Columbia - District of Columbia Department of Health
- Delaware - Delaware Prescription Assistance Program
- Guam - Guam Medically Indigent Program (MIP)
- Idaho - Idaho AIDS Drug Assistance Program (IDADAP)
- Indiana - HoosierRx
- Louisiana - Louisiana Department of Health
- Massachusetts - Prescription Advantage Executive Office of Elder Affairs
- Maryland - Maryland Senior Prescription Drug Assistance Program (SPDAP)
- Maine - Office of MaineCare Services
- Missouri - MissouriRx Plan (MORx)
- Montana - Montana Big Sky Rx
- New Jersey - New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD)
- Nevada - Nevada Senior/Disability Rx Program

- Pennsylvania - Pennsylvania PACE
- Rhode Island - Rhode Island Office of Healthy Aging
- Texas - Texas HIV State Pharmaceutical Assistance Program (SPAP)
- Virginia - Virginia Medication Assistance Program (MAP)
- Virgin Islands of the U.S. - US Virgin Islands Pharmaceutical Assistance Program
- Vermont - Green Mountain Care Prescription Assistance
- Wisconsin - Wisconsin SeniorCare Pharmaceutical Assistance Program

State Pharmaceutical Assistance Programs – Contact Information	
California | Department of Health Services - ADAP Insurance Assistance Section, P.O. Box 997426, MS 7704 Sacramento, CA 95899-7426 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_medpartd.aspx	1-844-421-7050 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Colorado | Colorado Department of Health Care Policy & Financing 1570 Grant ST Denver, CO 80103-1818 https://www.colorado.gov/hcpf/contact-hcpf	1-800-221-3943 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday
Connecticut | Connecticut AIDS Drug Assistance Program (CADAP) c/o Magellan Health, 15 Cornell RD, STE 2201 Lathan, NY 12110 https://ctdph.magellanrx.com/	1-800-424-3310 TTY 711 8 a.m. - 4 p.m. local time, Monday - Friday
District of Columbia | District of Columbia Department of Health AIDS Drug Assistance Program (ADAP) 899 N Capitol ST NE Washington, DC 20002 https://dchealth.dc.gov/node/137072	1-202-671-4900 TTY 711 8:15 a.m. - 4:45 p.m. local time, Monday - Friday
Delaware | Delaware Prescription Assistance Program DHSS Herman Holloway Campus, Lewis Building 1901 N. DuPont Highway New Castle, DE 19720 https://dhss.delaware.gov/dhss/dmma/dpap.html	1-800-996-9969 TTY 711 8 a.m. - 4:30 p.m. local time, Monday - Friday
Guam | Guam Medically Indigent Program (MIP) RAN-Care Commercial Building, CNU #207 761 South Marine Corps Drive Tamuning, GU 96913 http://dphss.guam.gov/bureau-of-economic-security/	1-671-635-7432 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday

State Pharmaceutical Assistance Programs – Contact Information	
Idaho | Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, P.O. Box 83720 Boise, ID 83720-0036 http://www.healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	1-208-334-6657 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Indiana | HoosierRx P.O. Box 6224 Indianapolis, IN 49206 https://www.in.gov/medicaid/members/194.htm	1-866-267-4679 TTY 711 8 a.m. - 4:30 p.m. local time, Monday - Friday
Louisiana | Louisiana Department of Health Medicare Savings Program, P.O. Box 629 Baton Rouge, LA 70802 http://dhh.louisiana.gov/index.cfm/page/236	1-888-342-6207 TTY 1-800-220-5404 8 a.m. - 4:30 p.m. local time, Monday - Friday
Massachusetts | Prescription Advantage Executive Office of Elder Affairs P.O. Box 15153 Worcester, MA 01615-0153 https://www.prescriptionadvantagema.org/	1-800-243-4636 TTY 1-877-610-0241 9 a.m. - 5 p.m. local time, Monday - Friday
Maryland | Maryland Senior Prescription Drug Assistance Program (SPDAP) c/o International Software Systems Inc. PO Box 749 Greenbriar, MD 20768-0749 www.marylandspdap.com	1-800-551-5995 TTY 1-800-877-5156 8 a.m. - 5 p.m. local time, Monday - Friday
Maine | Office of MaineCare Services 109 Capitol ST 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms	1-800-977-6740 TTY 711 7 a.m. - 6 p.m. local time, Monday - Friday
Missouri | MissouriRx Plan (MORx) 615 Howerton CT P.O. Box 6500 Jefferson City, MO 65102-6500 https://dss.mo.gov/mhd/faq/pages/faqmo_rx.htm	1-800-392-2161 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Montana | Montana Big Sky Rx P.O. Box 202915 Helena, MT 59620-2915 www.bigskyrx.mt.gov	1-866-369-1233 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday

State Pharmaceutical Assistance Programs – Contact Information	
New Jersey | New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD) P.O. Box 715 Trenton, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/paad/	1-800-792-9745 TTY 711 8:30 a.m. - 4:30 p.m. local time, Monday - Friday
Nevada | Nevada Senior/Disability Rx Program 1860 E Sahara AVE Las Vegas, NV 89104 http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/	1-866-303-6323 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Pennsylvania | Pennsylvania PACE P.O. Box 8806 Harrisburg, PA 17105-8806 https://pacecares.magellanhealth.com	1-800-225-7223 TTY 1-800-222-9004 8:30 a.m. - 5 p.m. local time, Monday - Friday
Rhode Island | Rhode Island Office of Healthy Aging 25 Howard AVE, BLDG 57 Cranston, RI 02920 https://oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance	1-401-462-0560 TTY 1-401-462-0740 8:30 a.m. - 4 p.m. local time, Monday - Friday
Texas | Texas HIV State Pharmaceutical Assistance Program (SPAP) P.O. Box 149347, MC 1873 Austin, TX 78714 https://www.dshs.state.tx.us/hivstd/meds/spap.shtm	1-800-255-1090 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Virginia | Virginia Medication Assistance Program (MAP) P.O. Box 2448 Richmond, VA 23218-2448 https://www.vdh.virginia.gov/disease-prevention/vamap/	1-855-362-0658 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Virgin Islands of the U.S. | US Virgin Islands Pharmaceutical Assistance Program 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 http://www.dhs.gov.vi/seniors/pharmaceutical.html	1-340-774-0930 TTY 711
Vermont | Green Mountain Care Prescription Assistance Department of Vermont Health Access, 280 State DR Waterbury, VT 05671-1020 https://dvha.vermont.gov/members/prescription-assistance	1-800-250-8427 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday

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

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit Medicare.gov to find out if this payment option is right for you.

Method	The Medicare Prescription Payment Plan - Contact Information
Call	**1-855-409-0219** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	**UAWTrustPDP.com**

Section 8 How to contact the Railroad Retirement Board

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

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

Chapter 3

Using the plan's coverage for Part D prescription drugs

Section 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter **or you can fill your prescription through the plan's mail-order service**.)
- Your drug must be on the plan's **List of Covered Drugs (Formulary)** (we call it the Drug List for short). (See Section 3 in this chapter.)
- 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 references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 in this chapter for more information about restrictions on your coverage.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Pharmacy Directory**, visit our website (UAWTrustPDP.com), and/or call Customer Service.

You may go to any of our network pharmacies.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from

Customer Service or use the **Pharmacy Directory**. You can also find information on our website at UAWTrustPDP.com.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, look in your **Pharmacy Directory** (UAWTrustPDP.com) or call Customer Service.

Section 2.3 Using the plan's mail-order service

As a member of our plan, you have options for mail-order services.

- Our plan's preferred mail-order service, **Optum® Home Delivery Pharmacy**, allows you to order up to a 90-day supply for **most maintenance medication**. To get order forms and information about filing your prescriptions by mail you must contact Optum Home Delivery Pharmacy at 1-877-629-3123, or for the hearing impaired, (TTY) 711, 24 hours a day, 7 days a week.
- If you use a network mail service pharmacy that is not Optum Home Delivery Pharmacy, your costs may vary. Please reference your Pharmacy Directory to find the mail service pharmacies in our network.
- If you use a mail service pharmacy not in the plan's network, your prescription will not be covered.

For questions about mail-order service, please contact Customer Service at 1-855-409-0219.

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

If your prescription is on file at your local pharmacy, go to your pharmacy to fill the prescription. If your delayed prescription is not on file at your local pharmacy, then please ask your doctor to call in a new prescription to your pharmacist. Or, your pharmacist can call the doctor's office for you to request the prescription. **Your pharmacist can call the Pharmacy help desk at 1-877-889-6510, (TTY) 711, 24 hours a day, 7 days a week if he/she has any problems, questions, concerns, or needs a claim override for a delayed prescription.**

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

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

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

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

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

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 10 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling Optum Rx® at 1-877-889-5802.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Please keep your mail order pharmacy informed about the best way(s) to contact you, so the pharmacy can reach you to confirm your order before shipping. You can do this by contacting the mail order pharmacy when you set up your auto refill program and also when you receive notifications about upcoming refill shipments.

Optum Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. There may be other pharmacies in our network.

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.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your **Pharmacy Directory** (UAWTrustPDP.com) 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. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy **only** when you are not able to use a network pharmacy. To help you, we have network pharmacies outside our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Service** to see if there is a network pharmacy nearby. 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.

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

- **Prescriptions for a medical emergency**
  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Drug List without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling or out of the service area**
  When traveling within the U.S. you have access to network pharmacies nationwide. Bring your prescriptions and medication with you and be sure to check the pharmacy directory for your travel plans to locate a network pharmacy while traveling. If you are leaving the country, you may be able to obtain a greater day supply to take with you before leaving for the country where there are no network pharmacies available.
- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy that provides 24-hour service is not within reasonable driving distance.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.

How do you ask for reimbursement from the plan?

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

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 meets Medicare's requirements and has been approved by Medicare.

The drugs on the Drug List are only those covered under Medicare Part D.

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 drug is 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 for the diagnosis or condition for which it is being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 10 for definitions of the types of drugs that may be on the Drug List.

What is not on the Drug List?

The plan does not cover all prescription drugs.

- If your drug is not included on the Drug List, you may call Customer Service to find out if we cover it or what alternatives are available.
- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more information about this, see Section 7.1 in this chapter.)
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the Drug List. (For more information, please see Chapter 7.)

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

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

Tier 1 † - Most generic drugs, including Part D eligible generic compound medications.

Tier 2 † - Many common brand name drugs, called preferred brands, some higher-cost generic drugs and vaccines, and Part D eligible brand compound medications.

Tier 3 - Non-preferred generic and non-preferred brand name drugs.

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

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

†Our plan covers most Part D vaccines at no cost to you. For some vaccines, you will need to pay the applicable copayment.

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. Visit the plan's website (UAWTrustPDP.com) for the most current information.
2. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

Section 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 What kinds of restrictions?

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7)

What is a compounded drug?

A compounded drug is created by a pharmacist by combining or mixing ingredients to create a prescription medication customized to the needs of an individual patient.

Does my Part D plan cover compounded drugs?

Generally compounded drugs are non-formulary drugs (not covered) by your plan. You may need to ask for and receive an approved coverage determination from us to have your compounded drug covered. Compounded drugs may be Part D eligible if they meet all of the following requirements:

1. Contains at least one FDA, or Compendia, approved drug ingredient, and all ingredients in the compound (including their intended route of administration) are supported in the Compendia.
2. Does not contain a non-FDA approved or Part D excluded drug ingredient
3. Does not contain an ingredient covered under Part B. (If it does, the compound may be covered under Part B rather than Part D)
4. Prescribed for a medically accepted condition

The chart below explains the basic requirements for how a compound with 2 or more ingredients may or may not be covered under Part D rules, as well as potential costs to you.

Compound Type	Medicare Coverage
Compound containing a Part B eligible ingredient	Compound is covered only by Part B
Compound containing all ingredients eligible for Part D coverage and all ingredients are approved for use in a compound	Compound may be covered by Part D upon approved coverage determination
Compound containing ingredients eligible for Part D coverage and approved for use in a compound, and ingredients excluded from Part D coverage (for example, over the counter drugs, etc.)	Compound may be covered by Part D upon approved coverage determination. However, the ingredients excluded from Part D coverage will not be covered and you are not responsible for the cost of those ingredients excluded from Part D coverage
Compound containing an ingredient not approved or supported for use in a compound	Compound is not covered by Part D. You are responsible for the entire cost

What do I have to pay for a covered compounded drug?

A compounded drug that is Part D eligible may require an approved coverage determination to be covered by your plan. You will pay either the preferred generic or preferred brand copay for compounded drugs that are approved. If the approved compounded drug contains only generic drug ingredients, then you will pay the preferred generic copay. If the approved compounded drug contains at least one brand name drug ingredient, then you will pay the preferred brand copay. No further tier cost share reduction allowed or available.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan, based on specific criteria, before we will agree to cover the drug for you. We recommend that you have your provider complete this for you. This is called **"prior authorization."** This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

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

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

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our drug list (formulary) or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- 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.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the 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 options:

- You may be able to get a temporary supply of the drug.

- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change.

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

- If you are a new member, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- We will cover a temporary supply of your drug during the first 90 days of the plan year.
- This temporary supply will be for at least a 31-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to at least a 31-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**
  We will cover at least a 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those current members with level of care changes:**
  There may be unplanned transitions such as hospital discharges (including psychiatric hospitals) or level of care changes (i.e., changing long-term care facilities, exiting and entering a long-term care facility, ending Part A coverage within a skilled nursing facility, or ending hospice coverage and reverting to Medicare coverage) that can occur anytime. If you are prescribed a drug that is not on our Drug List or your ability to get your drugs is restricted in some way, you are required to use the plan's exception process. For most drugs, you may request a one-time temporary supply of at least 31 days to allow you time to discuss alternative treatment with your doctor or to request a Drug List (formulary) exception. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 31 day supply.

For questions about a temporary supply, call Customer Service.

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

1)You can change to another drug

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

2)You can ask for an exception

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

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

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

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. 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 it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

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

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

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each plan year. However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

See Chapter 10 for definitions of the drug types discussed in this chapter.

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our website regularly. This section describes the types of changes we may make to the Drug List and when you will get direct notice if changes are made for a drug that you are taking.

Changes we may make to the Drug List that affect you during the current plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
  - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We will make these immediate changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.

- We will tell you at least 30 days before we make the change, or tell you about the change and cover at least a 31-day fill of the version of the drug you are taking.

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you after we make the change.

- **Making other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 31-day fill of the drug you are taking.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 7.

Changes to the Drug List that do not affect you during the current plan year

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

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

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year. If we make a change effective January 1 of the next plan year, we will make every effort to notify you 30-60 days prior to the change.

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. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 7.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan cannot cover **off-label** use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. **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.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

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

In addition, if you are **receiving Extra Help** from Medicare to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call Customer Service for more information.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

Section 8 Filling a prescription

Section 8.1 Provide your member ID information

To fill your prescription, provide your member ID information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically

bill the plan for **our** share of your 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 member ID information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment 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 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 or to a skilled nursing facility, Original Medicare (or your Medicare health plan with Part A and B coverage, if applicable) will generally cover the cost of your prescription drugs during your stay. In some cases, you may need to ask us to reimburse you for our share of the cost. (Chapter 5, Section 2 explains how to ask the plan to pay you back.) Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

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

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

Check your **Pharmacy Directory** (UAWTrustPDP.com) to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

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

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

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

Your enrollment in UAW Trust MedicareRx (PDP) 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 UAW Trust MedicareRx (PDP) 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 UAW Trust MedicareRx (PDP) for the drug.

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

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

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

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

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

In general, if you have employee or other retiree group coverage, the drug coverage you get from us will be **secondary** to your group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

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

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

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need this notice to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from UAW Retiree Medical Benefits Trust.

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because they are unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drugs are unrelated before our plan can cover the drugs. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

Section 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

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

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

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

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 7 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

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

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

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about 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 which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and keep it with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about these programs, please contact Customer Service.

Chapter 4

What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider."

Section 1 Introduction

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

This chapter focuses on what you pay for Part D prescription drugs. Your plan sponsor offers additional prescription drug coverage. Please see your Additional Drug Coverage list for more information. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

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

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

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called a copayment.

- **A copayment** is a fixed amount you pay each time you fill a prescription.

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

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

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

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3):

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

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are **also included** in your out-of-pocket costs 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, employer or union health plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,000 in out-of-pocket costs within the plan year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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

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

- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan
- Payments for your drugs that are made by the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program (a program where drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics)

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Service.

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

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

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

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

There are three "drug payment stages" for standard Medicare Part D plans. The plan selected by UAW Retiree Medical Benefits Trust determines your plan costs. Details of your plan are described in Sections 4 through 7 of this chapter. Here are the standard stages:

Stage 1: Yearly Deductible Stage (There is no deductible for the plan)

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

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

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

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

- We keep track of how much you have paid. This is called your **out-of-pocket** costs (what you pay including coverage gap discount program payments). This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a Part D EOB. The Part D EOB includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1**. This is called "year-to-date" information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This information will display the total drug price, and any percentage change from first fill for each prescription claim of the same quantity.

- **Available lower cost alternative prescriptions**. This will include information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

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 member ID card when you get a prescription filled**. This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of these receipts. Here are examples of when you should give us copies of your drug receipts:
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
  - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.
- **Send us information about the payments others have made for you**. Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. You can also view your EOB on our website at UAWTrustPDP.com. Be sure to keep these reports. They are an important record of your drug expenses.

Section 4 There is no deductible for the plan

Your plan provides additional coverage, which means you do not pay a deductible for your Part D drugs. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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

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

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

The plan has 3 cost-sharing tiers

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

Tier 1 † - Most generic drugs, including Part D eligible generic compound medications.

Tier 2 † - Many common brand name drugs, called preferred brands, some higher-cost generic drugs and vaccines, and Part D eligible brand compound medications.

Tier 3 - Non-preferred generic and non-preferred brand name drugs.

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

†Our plan covers most Part D vaccines at no cost to you. For some vaccines, you will need to pay the applicable copayment.

Your pharmacy choices

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

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

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

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

During the Initial Coverage Stage, your share of the cost of a covered drug will never be more than your copayment.

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

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

The table below shows what you pay when you get a 31-day supply and a long-term up to a 90-day supply of a drug.

Your share of the cost when you get a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (up to a 31-day supply)^	Standard retail cost-sharing (in-network) (up to a 90-day supply)^	Mail-order cost-sharing (up to a 90-day supply)^
Tier 1 † [1]	$0	$0	$0
Tier 2 † [1]	$33 copayment	$99 copayment	$33 copayment
Tier 3 [1]	$115 copayment	$345 copayment	$115 copayment

[1] You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan.

^Most specialty drugs are limited to a 31-day supply through retail and mail order.

†Our plan covers most Part D vaccines under the Part D prescription drug benefit at no cost to you when received from a network pharmacy. For some vaccines, you will need to pay the applicable copayment.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Your pharmacy out-of-pocket maximum
When your total out-of-pocket costs (what you pay) for Tier 2 drugs reach $1,000, you will pay a $0 copayment for Tier 2 drugs for the rest of the plan year. The pharmacy out-of-pocket maximum starts over on January 1st of each year.

Please see Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

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

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

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

- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per

day for your drug (the “daily cost-sharing rate”) and multiply it by the number of days of the drug you receive.

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,000.** You then move on to the Catastrophic Coverage Stage.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the $2,000 limit in a year.
We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

Section 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 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 payment stage, the plan pays the full cost for your Medicare-covered Part D drugs. You pay nothing.
- For additional drugs covered under our enhanced benefit, you will pay the Initial Coverage cost shares listed in Section 5.2.

Section 7 Additional benefits information

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

1. Medications will not be covered if prescribed by physicians or other providers who are excluded or precluded from the Medicare program participation.
2. You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days supply.
3. Costs for drugs that are not covered under Part D do not count toward your Out-of-Pocket costs.

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

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find

these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. For some vaccines, you will need to pay the applicable copayment. Refer to your plan's Drug List or contact Customer Service for coverage and cost-sharing details about specific vaccines.

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

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

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

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccinations are recommended by ACIP and cost you nothing. For some vaccines, you will need to pay the applicable copayment.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

Chapter 5

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

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

Sometimes when you get a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan, or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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 **Drug List** 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

Section 2 How to ask us to pay you back

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt(s) documenting the payment you have made. It's a good idea to make a copy of your receipt(s) for your records.

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

Part D prescription drug payment requests:
Optum Rx
P.O. Box 650287
Dallas, TX 75265-0287

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

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

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

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

- If we decide that the drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). We will mail your reimbursement of our share of the cost to you.
- If we decide that the drug is **not** covered, or you did **not** follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

Chapter 6

Your rights and responsibilities

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

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

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

Our plan has free 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 at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held by 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.

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

Effective January 1, 2024

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

The terms "information" or "health information" in this notice include information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the

requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to confirm we are meeting our privacy obligations.

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

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- **For Health Care Operations** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors**, if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

- **For Underwriting Purposes**; however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders**, we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

    1. Alcohol and Substance Use Disorder
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

We will follow the more stringent and protective law, where it applies to us.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for

certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For information on how to revoke your authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

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

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; (iii) to correctional institutions or law enforcement officials; and

(iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, **please call the toll-free member phone number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-855-409-0219 (TTY/RTT 711).**
- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at the following address:

  UnitedHealthcare

  Customer Service - Privacy Unit

  PO Box 740815

  Atlanta, GA 30374-0815
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

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

[1]This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Financial Information Privacy Notice

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

Effective January 1, 2024

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

Information We Collect

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

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

Disclosure of Information

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

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

Confidentiality and Security

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

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-855-409-0219 (TTY 711).**

[2] For purposes of this Financial Information Privacy Notice, “we” or “us” refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc; OptumHealth Care Solutions, LLC; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holding, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. For a current list of entities subject to this notice go to www.uhc.com/privacy/entities-fn-v1

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

As a member of our plan, you have the right to get several kinds of information from us. We may also call you occasionally to let you know about other Medicare products and services we offer. Call Customer Service if you want to opt out of receiving these calls or want any of the following kinds of information:

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

- **Information about our plan.** This includes, for example, information about the plan’s financial condition.
- **Information about our network pharmacies.**
  - You have the right to get information about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.

- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

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

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, **if you want to**, you can:

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state-specific agency, for example, your State Department of Health.

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do.

Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

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

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

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

Is it about something else?

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

- You can **call Customer Service**.
- You can **call the SHIP.** For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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

- You can **call Customer Service**.
- For information on the quality program for your specific health plan, call Customer Service. You can also access this information online at uhc.com/medicare/resources.html. Open the

Additional Medicare information and forms section and select Find information. Then select Other resources and plan information and then Commitment to quality.

- You can **call the SHIP.** For details, go to Chapter 2, Section 3.
- You can contact **Medicare.**
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this **Evidence of Coverage** to learn what is covered for you and the rules you need to follow to get your covered drugs.
  - Chapters 3 and 4 give the details about your Part D prescription drug coverage.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan member ID card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - Your prescription drug coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium, if applicable. If you have a plan premium, you must pay your plan premiums to continue being a member of our plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.

- **If you move outside of our plan service area, you cannot remain a member of our plan.**
- **If you move within our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Chapter 7

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

Section 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

- Uses simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "coverage determination" or "at-risk determination," and "independent review organization" instead of "Independent Review Entity."
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

Section 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Skip ahead to **Section 7** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

Coverage decisions and appeals

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

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

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

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your 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.

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

Making an appeal

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

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

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

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 5 of this chapter. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 6 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

- You **can call us at Customer Service**.
- **You can get free help** from your State Health Insurance Assistance Program.

- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

- **You can ask someone to act on your behalf**. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or another person to be your representative, call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer**. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

- **This section is about your Part D drugs only**. To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "drug list" instead of "List of Covered Drugs" or "Formulary."
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

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

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

This section tells what you can do if you are in any of the following situations:

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

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 5.2 What is an exception?

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

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

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 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 Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our **Drug List**. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment 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 3 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
   - If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
   - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
   - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
   - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

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

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

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

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

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

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

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

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website (UAWTrustPDP.com). Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

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

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

Deadlines for a "fast coverage decision"

- We must generally give you our answer within **24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must generally give you our answer within **72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the** coverage we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

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

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

A "fast appeal" is also called an **"expedited redetermination."**

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

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

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

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

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-855-409-0219.** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Redetermination Request Form, which is available on our website (UAWTrustPDP.com). Please

be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.

- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

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

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer within **72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.

  If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard" appeal for a drug you have not yet received

- For standard appeals, we must give you our answer within **7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.

  If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" about payment for a drug you have already bought

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

  If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

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

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for "fast appeal"

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

Deadlines for "standard appeal"

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal **within 14 calendar days** after it receives your request.

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

For "fast appeals":

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For "standard appeals":

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

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision." It is also called "turning down your appeal.") In this case, the independent review organization will send you a letter:

- Explaining its decision.

- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6 Taking your appeal to Level 3 and beyond

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

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

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

Making complaints

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

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

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

Complaint	Example
Quality of your care	Are you unhappy with the quality of the care you have received?
Respecting your privacy	Did someone not respect your right to privacy or shared confidential information?
Disrespect, poor customer service, or other negative behaviors	Has someone been rude or disrespectful to you? Are you unhappy with our Customer Service? Do you feel you are being encouraged to leave the plan?

Complaint	Example
Waiting times	□Have you been kept waiting too long by pharmacists? Or by Customer Service or other staff at our plan? □ Examples include waiting too long on the phone, in the waiting room, or getting a prescription.
Cleanliness	□Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	□Did we fail to give you a required notice? □Is our written information hard to understand?
Timeliness (These types of complaints are all related to the **timeliness** of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: □You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. □You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. □You believe we are not meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. □You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

Legal Terms

□A **"Complaint"** is also called a **"grievance."**

□**"Making a complaint"** is also called **"filing a grievance."**

□**"Using the process for complaints"** is also called **"using the process for filing a grievance."**

□A **"fast complaint"** is also called an "**expedited grievance.**"

Section 7.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step**. If there is anything else you need to do, Customer Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us**. If you put your complaint in writing, we will respond to your complaint in writing.
- We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.
- If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address/fax numbers for filing complaints is located in Chapter 2, Section 1 under "How to contact us when you are making a complaint about your Part D prescription drugs."
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

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

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

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 7.5 You can also tell Medicare about your complaint

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

Chapter 8

Ending your membership in the plan

Section 1 Introduction to ending your membership in our plan

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

- You might leave our plan because you have decided that you **want** to leave. Section 2 provides information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 4 tells you about situations when we must end your membership.

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

In the event you choose to end your membership in our plan, re-enrollment may not be permitted, or you may have to wait until your plan sponsor's next Open Enrollment Period. You should consult with your plan sponsor regarding the availability of other coverage prior to ending your plan membership outside of your plan sponsor's Open Enrollment Period. It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting your request to end your membership in our plan.

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

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

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

- Call your plan sponsor
- **Call Customer Service.**
- Find the information in the **Medicare & You 2025** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

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

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

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

- We are notified that you no longer meet the eligibility requirements of UAW Retiree Medical Benefits Trust (plan sponsor).
- UAW Retiree Medical Benefits Trust's (plan sponsor's) contract with us is terminated.
- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, 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 are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Customer Service.

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

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

What should you do if this happens?

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

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

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

Chapter 9
Legal notices

Section 1 Notice about governing law

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

Section 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

Section 4 Third party liability and subrogation

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

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

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

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

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

The following persons and entities are considered third parties:

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

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

The following is agreed upon between you and us:

- You will cooperate with us in protecting our legal rights to subrogation and reimbursement; and you acknowledge that our rights under this Section will be considered as the first priority claim against any Third Parties, to be paid before any of your other claims are paid. Specifically, but without limitation, you agree to: (i) provide any relevant information we may request; (ii) sign and deliver such documents as we or our agents may reasonably request to secure the subrogation claim; (iii) respond to requests for information about any accidents or injuries; (iv) make court appearances; (v) obtain the consent of the plan or our agents before releasing any party from liability for or payment of medical expenses. We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf; and (vi) you may not accept any settlement that does not fully reimburse us without its written approval.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- You will do nothing to prejudice our rights under this provision, either before or after the need for drugs under this EOC. We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit on our own behalf as your subrogee. Your failure to cooperate in this manner shall be deemed a breach of this contract and may result in the institution of legal action against you.
- We will not use the rights enumerated throughout this Section to affect or impair any parental financial obligations, such as child support, associated with Pregnancy.
- No court costs or attorneys fees may be deducted from our recovery without our express written consent; and no so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right. We are not required to participate in or pay court costs or attorneys fees to any attorney or other representative or agent hired by you to pursue a claim relating to your Sickness or Injury.
- We may collect, at our opinion, amounts from proceeds of any Third Party settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether you or your legal representative have been made whole. You will hold any proceeds of such a Third Party settlement or judgment in a constructive trust for our benefit under these subrogation provisions. We will be entitled to recover from you reasonable attorney fees incurred in collecting proceeds held by you.
- The plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages.
- The plan’s rights to recovery will not be reduced due to your own negligence.
- We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer’s legal representative or other third party and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor’s Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- We have the responsibility for administering the terms and conditions of the subrogation and reimbursement rights and have such powers and duties as are necessary to discharge these duties and functions, including the exercise of discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Section 5 Member liability

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

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

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

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

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

Section 7 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network pharmacies may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network pharmacies shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

Section 8 Contracting network pharmacies

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

Section 9 Disclosure

Plans are provided by UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Section 10 Member statements

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

Section 11 Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

Section 12 Commitment of Coverage Decisions

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

Chapter 10

Definitions of important words

Chapter 10

Definitions of important words

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

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

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also Original Biological Product and Biosimilar).

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See Interchangeable Biosimilar).

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 that begins when you (or other qualified parties on your behalf) have spent $2,000 for Medicare-covered Part D drugs during the covered year. During this payment stage, you pay nothing for your Medicare-covered Part D drugs and for additional drugs that are covered under our enhanced benefit.

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

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

Compendia – Medicare-recognized reference books for drug information and medically accepted indications for Part D coverage.

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

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

Cost-Sharing – Cost-sharing refers to the amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a

specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 3 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

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

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

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

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

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

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

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

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

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a

bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, 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 decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our 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 our plan or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

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

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical

costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

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

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

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

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

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must

pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

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

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Plan Sponsor – Your former employer, union group or trust administrator.

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

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

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our drug list (formulary). Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

Service Area – A geographic area where you must live to join a particular prescription drug plan. The plan may disenroll you if you permanently move out of the plan's service area.

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

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.

UAW Trust MedicareRx (PDP) Customer Service:

Call **1-855-409-0219**

Calls to this number are free. 8 a.m.-8 p.m. local time, Monday-Friday. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**

Calls to this number are free. 8 a.m.-8 p.m. local time, Monday-Friday.

Write **P.O. Box 30770**
Salt Lake City, UT 84130-0770

UAWTrustPDP.com

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.
You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

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