County of Orange Medicare Prescription Drug Plan (PDP)

Your 2023 Evidence of Coverage

Administered by Optum Rx®
Effective January 1, 2023 – December 31, 2023

This document provides details about your Medicare prescription drug coverage and how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Optum Rx Member Services

Phone (toll-free)**:**	**1-800-908-9097**
TTY users:	**711**
Hours of operation:	24 hours a day, 7 days a week
Website:	**optumrx.com**

This plan is offered by County of Orange referred to throughout the *Evidence of Coverage* as "we," "us," or "our." The County of Orange Medicare Prescription Drug Plan is referred to as "plan" or "our plan."

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

Table of Contents

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

Chapter 1: Getting Started as a Member

SECTION 1 Introduction

Section 1.1 What is the *Evidence of Coverage* document about?

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

If you are a new member, it is 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.

The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of the County of Orange Medicare Prescription Drug Plan.

If you are confused or concerned, or just have a question, contact Optum Rx. Our contact information is on the front cover of this document.

Section 1.2 Legal information about the *Evidence of Coverage*

It is part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how the County of Orange Medicare Prescription Drug Plan covers your care. Other parts of this contract include the Drug List (Formulary) and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in our plan between January 1, 2023, and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits for our plan after December 31, 2023. We can also choose to stop offering the plan or offer it in a different service area.

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

Section 2.1 Your eligibility requirements

You are eligible for coverage in our plan as long as you:

- Live in our geographic service area. (Section 2.3 below describes our service area.)
- Are entitled to Medicare Part A and enrolled in Medicare Part B. (You must have Part B.)
- Continue to pay your Part B premium.
- Are a United States citizen or lawfully present in the United States.
- Meet your plan's eligibility requirements.

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

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2023 handbook*.) Your Part D prescription drugs are covered under our plan.

Section 2.3 Here is the service area for the County of Orange Medicare Prescription Drug Plan

Although Medicare is a federal program, our plan is available only to individuals who live in our service area. To remain a member of our plan, you must keep living in this service area. Our service area includes the United States, the District of Columbia, Puerto Rico, Guam, the US Virgin Islands, Northern Mariana Islands, and American Samoa.

Note: You need a physical address on file to be enrolled in our plan.

If you plan to move out of the service area, contact Optum Rx. Our contact information is on the front cover of this document. When you move, you may have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

You must be a U.S. citizen to be a member of a Medicare plan. If you become incarcerated, or you are no longer lawfully present in the service area, you are considered outside the service area, which means you are no longer eligible for coverage and may be disenrolled.

It is also important that you call the Social Security Administration if you move or change your mailing address.

SECTION 3 What other materials will you get from us?

Section 3.1 Your member identification (ID) card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use our ID card for prescription drugs you get at network pharmacies. If you do not present your card at the pharmacy, you may be responsible for the full cost of the prescription drug and may or may not be reimbursed by the plan. If you are at the pharmacy and do not have your card, you can show them your Medicare (red, white, and blue) card, or call Optum Rx to verify coverage. Our contact information is on the front cover of this document.

Please carry your card with you at all times and remember to show it each time you get covered drugs. If your card is damaged, lost, or stolen, call Optum Rx right away and we will send you a new card. You may also print a temporary card from the member portal website at **optumrx.com**.

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

Section 3.2 Why network pharmacies are important and how to find them

Network pharmacies are those that have agreed to fill covered prescriptions for our plan members.

With few exceptions, you must get your prescriptions filled at one of our network pharmacies. You should only use an out-of-network pharmacy in emergency situations. If you use an out-of-network pharmacy, you may pay more for your prescriptions.

To find a list of our network pharmacies, you can visit our website at **optumrx.com** and use the "Pharmacy Locator" tool (found under the "Member Tools" tab). You can also call Optum Rx for help or to ask us to mail a copy of the list to you. Our contact information is on the front cover of this document.

An abridged list of pharmacy networks may be included in this document.

Section 3.3 The plan's Drug List (Formulary)

The plan has a list that shows which Part D prescription drugs are covered by the County of Orange Medicare Prescription Drug Plan. These lists are sometimes called formularies. We call ours the Drug List. The drugs on this list are selected with the help of a team of doctors and pharmacists and must meet requirements set by Medicare. The Drug List also shows any rules that restrict coverage for certain drugs.

Section 3.4 *The Explanation of Benefits*: A report of payments made for your prescription drugs

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

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

Your *EOB* is also available electronically through the Optum Rx member portal. If you choose to do this, you will get an email each month when your *EOB* Statement is available to view online.

Just follow these 4 easy steps:

1. Log on to the Optum Rx member portal at optumrx.com/public/landing
2. Click on the My profile tab
3. Select Communication preferences
4. Update your option to Paperless for the *EOB*

You can also ask for an *EOB* summary at any time by calling Optum Rx. Our contact information is on the front cover of this document.

SECTION 4 Your monthly payment (premium) for the County of Orange Medicare Prescription Drug Plan

Section 4.1 Your plan premium cost

As a member of our plan, you may pay a monthly plan premium. Please contact your former employer, union, or fund to find out more about what you may pay for your premium. You must also continue to pay your Medicare Part B premium to remain a member of the plan (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be less.

There are programs to help people with limited resources pay for their drugs. Chapter 2 explains more about these programs. If you qualify for one of these programs, enrolling might reduce your monthly plan premium.

If you are already enrolled and getting help from one of these programs, some of the payment information in this *Evidence of Coverage* may not apply to you. You will receive a separate notice that explains your drug coverage. If you are already enrolled and getting help from one of these programs and do **not** receive this notice, please call Optum Rx and ask for your "Low Income Subsidy Rider." The Low-Income Subsidy Rider (LIS) is a separate notice from this Evidence of Coverage for people who receive Extra Help, which is a federal program that pays some of the costs for prescription drug coverage.

In some situations, your plan premium could be more.

Some members are required to pay a Late Enrollment Penalty (LEP) because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they did not have creditable coverage. "Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. For these members, the plan's monthly premium may be higher. It will be the monthly plan premium plus the amount of their LEP.

If you are required to pay the LEP, the amount of your penalty depends on how long you waited before you enrolled in prescription drug coverage or how many months you were without drug coverage after you became eligible. You can find more information about the LEP in Chapter 4. **Note:** If you have an LEP, it may be part of your plan premium. If you do not pay the part of your premium that is the LEP, you could be disenrolled for failure to pay your plan premium.

Many members are required to pay other Medicare premiums.

Some people pay an extra amount for Part D because of their yearly income. If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you will pay the standard premium amount and an Income-Related Monthly Adjustment Amount (IRMAA). If your income is greater than $91,000 for an individual (or married individuals filing separately) or greater than $182,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- If you are required to pay the extra amount but do not, you will be disenrolled from the plan by the Centers for Medicare & Medicaid Services (CMS) and lose your prescription drug coverage.
- If you have to pay an extra amount, Social Security (not your Medicare plan) will send you a letter telling you what that extra amount will be.

You can find more information about Part D premiums based on income in Chapter 4. You can also:

- Visit medicare.gov or call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week
- Call Social Security at 1-800-772-1213, TTY 1-800-325-0778

Note: The income amount thresholds listed above may change during the year, or after you have received this document. For the most up to date information, please visit medicare.gov, or call Medicare at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

SECTION 5 Please keep your member records up to date

Section 5.1 How to help make sure we have accurate information about you

The pharmacists in the plan's network need to have correct information about you. **These network providers use your member record to know what drugs are covered for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your address or phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident

If you have been admitted to a nursing home

- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Optum Rx. Our contact information is on the front cover of this document.

Remember to also report any changes to your personal information to the Social Security Administration. You can find contact information for the Social Security Administration in Chapter 2.

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

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage we know about. Please read this information carefully. If it is correct, you do not need to do anything. If it is incorrect, or if you have other coverage that is not listed, please call Optum Rx. Our contact information is on the front cover of this document.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected.

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

SECTION 7 How other insurance works with our plan

Section 7.1 Plans pay in a certain order that depends on circumstances

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 payer. The secondary payer may not pay all of the uncovered costs.

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD).
    - If you are 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 is part of a multiple-employer plan in which at least one employer has more than 100 employees.
    - If you are over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or is part of a multiple-employer plan in which at least one employer 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 them:

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or if you need to update your insurance information, please call Optum Rx. Our contact information is on the front cover of this document. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1 County of Orange Medicare Prescription Drug Plan
(how to contact us, including how to reach Optum Rx)

How to contact Optum Rx and other important departments

For help with claims, billing, or ID card questions, call Optum Rx. Our contact information is on the front cover of this document. We are available to assist you 24 hours a day, 7 days a week.

Contact	Phone	TTY*	Fax	Mailing Address
Optum Rx Member Services	**1-800-908-9097**	711	1-866-235-3171	Optum Rx Attn: Member Services 6868 W 115th St Overland Park, KS 66211
Prior Authorization & Clinical Coverage Decisions	**1-800-908-9097**	711	1-844-403-1028	Optum Rx Prior Authorization Department PO Box 25183 Santa Ana, CA 92799
Prior Authorization & Clinical Appeals	**1-800-908-9097**	711	1-877-239-4565	Optum Rx Prior Authorization Department c/o Appeals Coordinator PO Box 25184 Santa Ana, CA 92799
Comments, Complaints & Grievances	**1-800-908-9097**	711	1-866-235-3171	Optum Rx Attn: Part D Grievances 6868 W 115th St Overland Park, KS 66211
Manual Claims Submission, Payment Requests, & Claim Appeals	**1-800-908-9097**	711	n/a	Optum Rx Attn: Manual Claims PO Box 650287 Dallas, TX 75265-0287

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

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 or older, some people under 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 (CMS). This agency contracts with Medicare Prescription Drug Plans, including Optum Rx.

Medicare	
CALL	**1-800-MEDICARE (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 difficulty hearing or speaking. Calls to this number are free.
WEBSITE	**medicare.gov** This is the official government website for Medicare. It provides 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 and tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also find Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using its computer. You can also call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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.

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to provide free local health insurance counseling to people with Medicare. A list of SHIP programs by state is shown below.

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

State Health Insurance Assistance Programs (SHIPs)		
State	**Agency Name**	**Phone Number**
AK	Medicare Information Office - Alaska Department of Health & Social Services	1-800-478-6065
AL	State Health Insurance Assistance Program (SHIP)	1-800-243-5463
AR	Senior Health Insurance Information Program (SHIIP)	1-800-224-6330
AS	(I-CARE) Insurance Counseling Assistance and Referrals for Elders	1-800-868-9095
AZ	Arizona State Health Insurance Assistance Program (SHIP)	1-800-432-4040
CA	California Health Insurance Counseling & Advocacy Program (HICAP)	1-800-434-0222
CO	Senior Health Insurance Assistance Program (SHIP)	1-888-696-7213
CT	CHOICES	1-800-994-9422
DC	DC SHIP	1-202-727-8370
DE	Delaware Medicare Assistance Bureau	1-800-336-9500
FL	Serving Health Insurance Needs of Elders (SHINE)	1-800-963-5337
GA	GeorgiaCares SHIP	1-866-552-4464
GU	Guam Medicare Assistance Program (GUAM MAP)	1-671-735-7415
HI	Hawaii SHIP	1-888-875-9229
IA	Senior Health Insurance Information Program (SHIIP)	1-800-351-4664

State Health Insurance Assistance Programs (SHIPs)		
State	**Agency Name**	**Phone Number**
ID	Senior Health Insurance Benefits Advisors (SHIBA)	1-800-247-4422
IL	Senior Health Insurance Program (SHIP)	1-800-252-8966
IN	State Health Insurance Assistance Program (SHIP)	1-800-452-4800
KS	Senior Health Insurance Counseling for Kansas (SHICK)	1-800-860-5260
KY	State Health Insurance Assistance Program (SHIP)	1-877-293-7447
LA	Senior Health Insurance Information Program (SHIIP)	1-800-259-5300
MA	Serving the Health Insurance Needs of Everyone (SHINE)	1-800-243-4636
MD	State Health Insurance Assistance Program (SHIP)	1-800-243-3425
ME	Maine State Health Insurance Assistance Program (SHIP)	1-800-262-2232
MI	MMAP, Inc.	1-800-803-7174
MN	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line	1-800-333-2433
MO	CLAIM	1-800-390-3330
MS	MS State Health Insurance Assistance Program (SHIP)	1-844-822-4622
NC	Seniors Health Insurance Information Program (SHIIP)	1-855-408-1212
ND	Senior Health Insurance Counseling (SHIC)	1-888-575-6611
NE	Nebraska SHIP	1-800-234-7119
NH	NH SHIP - ServiceLink Resource Center	1-866-634-9412
NJ	State Health Insurance Assistance Program (SHIP)	1-800-792-8820
NM	New Mexico ADRC-SHIP	1-800-432-2080
NV	Nevada Medicare Assistance Program (MAP)	1-800-307-4444
NY	Health Insurance Information Counseling and Assistance Program (HIICAP)	1-800-701-0501
OH	Ohio Senior Health Insurance Information Program (OSHIIP)	1-800-686-1578
OK	Oklahoma Medicare Assistance Program (MAP)	1-800-763-2828
OR	Senior Health Insurance Benefits Assistance (SHIBA)	1-800-722-4134
PA	APPRISE	1-800-783-7067
PR	State Health Insurance Assistance Program (SHIP)	1-877-725-4300
RI	Senior Health Insurance Program (SHIP)	1-888-884-8721
SC	(I-CARE) Insurance Counseling Assistance and Referrals for Elders	1-800-868-9095

State Health Insurance Assistance Programs (SHIPs)		
State	**Agency Name**	**Phone Number**
SD	Senior Health Information & Insurance Education (SHIINE)	1-800-536-8197
TN	TN SHIP	1-877-801-0044
TX	Texas Department of Aging and Disability Services (HICAP)	1-800-252-9240
UT	Senior Health Insurance Information Program (SHIP)	1-800-541-7735
VA	(I-CARE) Insurance Counseling Assistance and Referrals for Elders	1-800-868-9095
VI	Virgin Islands State Health Insurance Assistance Program (VISHIP)	1-340-772-7368
VT	Vermont State Health Insurance Assistance Program (SHIP)	1-800-642-5119
WA	Statewide Health Insurance Benefits Advisors (SHIBA)	1-800-562-6900
WI	WI State Health Ins. Assistance Program (SHIP)	1-800-242-1060
WV	WV State Health Ins. Assistance Program (WV SHIP)	1-877-987-4463
WY	Wyoming State Health Insurance Information Program (WSHIIP)	1-800-856-4398
Contact information is subject to change throughout the year. For the most up-to-date contact information, visit medicare.gov.		

SECTION 4 Quality Improvement Organization

(paid for by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization (QIO) for each state.

Your state's QIO has a group of doctors and other healthcare professionals who are paid by the federal government. They check on and help improve the quality of care for people with Medicare. QIOs are independent organizations and are not connected with our plan. A list of QIOs in each state we serve is shown below.

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

Quality Improvement Organizations (QIO)		
State	**Agency Name**	**Phone Number**
AK	Mountain-Pacific Quality Health Foundation	1-800-497-8232
AL	Alliant Health Solutions	1-888-519-4128
AR	TMF Quality Innovation Network	1-800-725-9216

Quality Improvement Organizations (QIO)		
State	**Agency Name**	**Phone Number**
AZ	Health Services Advisory Group (HSAG)	1-602-801-6600
CA	Health Services Advisory Group (HSAG)	1-602-801-6600
CO	Telligen	1-515-440-8600
CT	IPRO	1-800-852-3685
DC	IPRO	1-800-852-3685
DE	IPRO	1-800-852-3685
FL	Alliant Health Solutions	1-888-519-4128
GA	Alliant Health Solutions	1-888-519-4128
HI	Mountain-Pacific Quality Health	1-800-497-8232
IA	Telligen	1-515-440-8600
ID	Comagine Health	1-800-488-1118
IL	Telligen	1-515-440-8600
IN	QSource	1-800-528-2655
KS	Health Quality Innovators (HQI)	1-804-289-5320
KY	Alliant Health Solutions	1-888-519-4128
LA	Alliant Health Solutions	1-888-519-4128
MA	IPRO	1-800−852−3685
MD	IPRO	1-800-852-3685
ME	IPRO	1-800-852-3685
MI	Superior Health Quality Alliance	1-833-821-7472
MN	Superior Health Quality Alliance	1-833-821-7472
MO	Health Quality Innovators (HQI)	1-804-289-5320
MS	TMF Quality Innovation Network	1-800-725-9216
MT	Mountain-Pacific Quality Health	1-800-497-8232
NC	Alliant Health Solutions	1-888-519-4128
ND	Great Plains	1-800-458-4262
NE	TMF Quality Innovation Network	1-800-725-9216
NH	IPRO	1-800-852-3685
NJ	IPRO	1-800-852-3685
NM	Comagine Health	1-505-998-9898

Quality Improvement Organizations (QIO)		
State	**Agency Name**	**Phone Number**
NV	Comagine Health	1-702-385-9933
NY	IPRO	1-800-852-3685
OH	IPRO	1-800-852-3685
OK	Telligen	1-515-440-8600
OR	Comagine Health	1-503-279-0100
PA	Quality Insights	1-304-346-9864
PR	TMF Quality Innovation Network	1-800-725-9216
RI	IPRO	1-800-852-3685
SC	Health Quality innovators (HQI)	1-804-289-5320
SD	Great Plains	1-800-458-4262
TN	Alliant Health Solutions	1-888-519-4128
TX	TMF Quality Innovation Network	1-800-725-9216
UT	Comagine Health	1-801-892-0155
VA	Health Quality Innovators (HQI)	1-804-289-5320
VI	TMF Quality Innovation Network	1-800-725-9216
VT	IPRO	1-800-852-3685
WA	Comagine Health	1-800-949-7536
WI	Superior Health Quality Alliance	1-833-821-7472
WV	Quality Insights	1-304-346-9864
WY	Mountain-Pacific Quality Health	1-800-497-8232
Contact information is subject to change throughout the year. For the most up-to-date contact information, visit qioprogram.org.		

SECTION 5 Social Security

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount, but your income went down because of a life-

changing event, you can call Social Security to ask for reconsideration. You can also call them with questions about the amount.

Social Security Administration	
CALL	**1-800-772-1213** Calls to this number are free. Available 8:00 a.m.–7:00 p.m. ET, Monday–Friday You can use our 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 difficulty hearing or speaking. Calls to this number are free. Available 8:00 a.m.–7:00 p.m. ET, Monday–Friday
WEBSITE	**ssa.gov**

SECTION 6 Medicaid

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

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited income and resources. Some people with Medicare are also eligible for Medicaid. A list of all Medicaid programs is shown below.

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

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

State Medicaid Offices		
State	**Agency Name**	**Phone Number**
AL	Alabama Medicaid	1-334-242-5000
AK	Alaska Medicaid	1-800-780-9972
AR	Arkansas Medicaid	1-501-682- 8233
AZ	Arizona Health Care Cost Containment System (AHCCCS)	1-800-654-8713 or

State Medicaid Offices		
State	**Agency Name**	**Phone Number**
		1-800-523-0231
CA	Department of Health Care Services	**1-800-541-5555 or** 1-916-636-1980
CO	Health First Colorado	1-800-221-3943
CT	Connecticut Medicaid	1-855-626-6632
DC	DC Medicaid	1-202-727-5355
DE	Delaware Medicaid & Medical Assistance	1-866-843-7212
FL	Florida Agency for Health Care Administration	1-888-419-3456
GA	Georgia Medicaid	1-866-211-0950
GU	Department of Public Health and Social Services/Division of Public Welfare	1-735-7519, 1-735-3540, 1-735-7256 or 1-735-7375 (Central Office - Mangilao) 1-635-7429 or 1-635-7488 (Northern Office - Dededo) 1-828-7542 or 1-828-8524 (Southern Office - Inarajan)
HI	Hawaii Med-QUEST Division	1-**808-692-8099**
IA	Iowa Department of Human Services	1-800-338-8366 or 1-515-256-4606 (Des Moines area)
ID	Idaho Department of Health and Welfare	1-877-456-1233
IL	Illinois Department of Healthcare and Family Services	1-800-843-6154
IN	Indiana Family and Social Services Administration	1-800-457-8283
KS	Kansas Department for Children and Families	1-833-765-2003
KY	Kentucky Cabinet for Health and Family Services	1-855-306-8959
LA	Healthy Louisiana	1-855-229-6848
MA	Massachusetts Health and Social Services	1-877-623-6765
MD	Maryland Department of Health	1-855-642-8572
ME	Maine Department of Health and Human Services	1-800-977-6740
MI	Michigan Department of Health and Human Services	1-800-975-7630
MN	Minnesota Department of Human Services	1-800-366-5411

State Medicaid Offices		
State	**Agency Name**	**Phone Number**
MO	Missouri Department of Social Services	1-573-751-3425
MP	Northern Mariana Islands Medicaid	1-670-664-4880
MS	Mississippi Division of Medicaid	1-800-421-2408
MT	Montana Department of Public Health and Human Services	1-800-362-8312
NC	North Carolina Medicaid	1-888-245-0179
ND	North Dakota Department of Human Services	1-800-318-2596
NE	Nebraska Department of Health and Human Services	1-855-632-7633
NH	New Hampshire Department of Health and Human Services	1-888-901-4999
NJ	New Jersey Department of Human Services	1-800-356-1561
NM	New Mexico Human Services Department	1-888-997-2583
NV	Nevada Department of Health and Human Services	1-877-638-3472
NY	New York State Department of Health	1-800-505-5678
OH	Ohio Department of Medicaid	1-800-324-8680
OK	Oklahoma Health Care Authority	1-888-365-3742
OR	OregonHealthCare.gov	1-800-699-9075
PA	Pennsylvania Department of Human Services	1-844-626-6813
PR	Medicaid Program Department of Health	1-787-765-2929
RI	Rhode Island Executive Office of Health and Human Services	1-855-840-4774
SC	South Carolina Health Connections Medicaid	1-888-289-0709
SD	South Dakota Department of Health	1-800-597-1603
TN	Tennessee Department of Health	1-800-259-0701
TX	Texas Health and Human Services	1-800-335-8957
UT	Utah Department of Health Medicaid	1-801-538-6155
VA	Virginia Department of Medical Assistance Services	1-855-242-8282
VI	VI Medicaid Program	1-340-774-0930
VT	Department of Vermont Health Access	1-800-250-8427
WA	Washington Health Care Authority	1-800-200-1004
WI	Wisconsin Department of Health Services	1-800-362-3002

State Medicaid Offices		
State	**Agency Name**	**Phone Number**
WV	West Virginia Department of Health and Human Resources	1-877-716-1212
WY	Wyoming Department of Health	1-855-294-2127
Contact information is subject to change throughout the year. For the most up-to-date contact information, visit Medicaid.gov.		

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

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay some prescription drug costs.. Resources include your savings and stocks, but not your home or car. If you qualify, you can get help paying for your Medicare drug plan's monthly premium and prescription copayments. The amount Extra Help pays also counts toward your out-of-pocket costs.

Some people automatically qualify for Extra Help and do not need to apply. Medicare mails a letter to people who automatically qualify.

If you think you may qualify for Extra Help, call Social Security to apply for the program. (See Section 5 of this chapter for contact information.) You may also be able to apply at your state Medical Assistance or Medicaid office. A list of State Medical Assistance Offices is shown below. After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
AL	Medicaid Agency of Alabama	1-800-362-1504	1-334-242-5000	n/a
AK	Alaska Department of Health and Social Services	1-800-780-9972	1-907-465-3030	n/a
AR	Department of Human Services of Arkansas	1-800-482-5431	1-501-682-8233	1-800-482-8988
AZ	AHCCCS (a.k.a. Access) (formerly - Health Care Cost Containment of Arizona)	1-800-523-0231	1-602-417-4000	1-602-417-4000
CA	California Department of Health Services	n/a	1-916-636-1980	n/a
CO	Department of Health Care Policy and Financing of Colorado	1-800-221-3943	1-303-866-3513	n/a
CT	Department of Social Services of Connecticut	1-800-842-1508	1-860-951-9544	n/a
DC	Department of Health - District of Columbia	n/a	1-202-639-4030	n/a

State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
DE	Delaware Health and Social Services	1-800-372-2022	1-302-255-9500	n/a
FL	Florida Department of Children and Families	1-866-762-2237	1-850-487-1111	n/a
GA	Georgia Department of Human Services	1-877-423-4746	1-404-656-4507	n/a
HI	Department of Human Services of Hawaii	1-800-316-8005	1-808-524-3370	1-800-316-8005
IA	Department of Human Services of Iowa	1-800-338-8366	1-515-256-4606	n/a
ID	Idaho Department of Health and Welfare	1-877-456-1233	1-208-334-6700	n/a
IL	Illinois Department of Healthcare and Family Services	1-800-226-0768	1-217-782-4977	n/a
IN	Family and Social Services Administration of Indiana	1-800-403-0864	1-317-233-4454	n/a
KS	DCR (Formerly Department of Social and Rehabilitation Services of Kansas)	1-800-766-9012	1-785-296-3981	n/a
KY	Cabinet for Health Services of Kentucky	1-800-635-2570	1-502-564-4321	n/a
LA	Louisiana Department of Health and Hospital	1-888-342-6207	1-855-229-6848	1-877-252-2447
MA	Office of Health and Human Services of Massachusetts	1-800-841-2900	n/a	n/a
MD	Department of Health and Mental Hygiene	1-800-456-8900	1-410-767-5800	n/a
ME	Maine Department of Health and Human Services	1-800-977-6740	n/a	n/a
MI	Michigan Department Community Health	1-800-642-3195	1-517-373-3740	n/a
MN	Department of Human Services of Minnesota – MinnesotaCare	1-800-657-3672	1-651-431-2801	n/a
MO	Missouri Department of Social Services	1-855-373-4636	1-573-751-3425	n/a
MS	Office of the Governor of Mississippi	1-800-421-2408	1-601-359-6050	n/a

State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
MT	Montana Department of Public Health & Human Services-Division of Child and Adult Health Resources	1-800-362-8312	n/a	n/a
NC	North Carolina Department of Health and Human Services	1-888-245-0179	1-919-855-4100	n/a
ND	North Dakota Department of Human Resources	1-800-755-2604	1-701-328-2321	n/a
NE	Nebraska Department of Health and Human Services System	1-855-632-7633	1-402-471-3121	n/a
NH	New Hampshire Department of Health and Human Services	1-800-852-3345	1-603-271-4344	n/a
NJ	Department of Human Services of New Jersey	1-800-356-1561	n/a	1-800-356-1561
NM	Department of Human Services of New Mexico	1-888-997-2583	1-505-827-3100	1-800-432-6217
NV	Nevada Department of Health and Human Services Division of Welfare and Supportive Services	1-800-992-0900	1-702-631-7098	n/a
NY	Office of Medicaid Inspector General (formerly New York State Department of Health)	1-800-541-2831	1-518-473-3782	n/a
OH	Department of Job and Family Services of Ohio - Ohio Health Plans	1-800-324-8680	n/a	n/a
OK	Health Care Authority of Oklahoma	1-800-987-7767	1-405-522-7171	n/a
OR	Oregon Department of Human Services	1-800-527-5772	1-503-945-5712	n/a
PA	Department of Human Services	1-800-692-7462	n/a	n/a
RI	Department Human Services	n/a	1-401-462-5300	n/a
SC	South Carolina Department of Health and Human Services	1-888-549-0820	1-803-898-2500	n/a
SD	Department of Social Services of South Dakota	1-800-597-1603	1-605-773-3495	1-800-305-9673
TN	TennCare Medicaid	1-800-342-3145	n/a	1-866-311-4290
UT	Utah Department of Health	1-800-662-9651	1-801-538-6155	1-800-662-9651
VA	Department of Medical Assistance Services	n/a	1-804-786-7933	n/a
VT	Agency of Human Services of Vermont	1-800-250-8427	1-802-871-3009	n/a

State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
WA	Health Care Authority	1-800-562-3022	n/a	n/a
WV	West Virginia Department of Health & Human Resources	1-877-716-1212	1-304-558-1700	n/a
WI	Wisconsin Department of Health Services	1-800-362-3002	1-608-266-1865	n/a
WY	Wyoming Department of Health	n/a	1-307-777-7656	n/a
Contact information is subject to change throughout the year. For the most up-to-date contact information, visit medicare.gov.				

State Pharmaceutical Assistance Programs

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

These programs provide financial help with prescription drugs for those with limited income, medically needy seniors, and individuals with disabilities. A list of State Pharmaceutical Assistance Programs is shown starting on the next page.

State Pharmaceutical Assistance Programs (SPAPs)		
State	**Agency Name**	**Phone Number(s)**
AL	Alabama AIDS Drugs Assistance Program	1-334-206-5853
AR	Arkansas Ryan White Part B/ADAP Program	1-501-661-2862
AZ	Arizona AIDS Drug Assistance Program (ADAP) Assist	1-602-542-7344
CA	CDPH, Office of AIDS, AIDS Drug Assistance Program	1-844-421-7050
CO	Bridging the Gap Colorado	1-303-692-2687
CT	CT ADAP	1-800-424-3310
DC	DC ADAP	1-202-671-4810
DE	Delaware Prescription Assistance Program	1-800-996-9969
FL	AIDS Drug Assistance Program	1-850-901-6677
GA	Georgia AIDS Drug Assistance Program	1-404-463-0416
IA	Iowa Department of Public Health (ADAP Program)	1-515-725-2011
ID	IDAGAP	1-208-334-6526
IL	Illinois AIDS Drug Assistance Program	1-217-524-5983
IN	HoosierRx	1-866-267-4679
KS	Kansas ADAP	1-785-296-1982

State Pharmaceutical Assistance Programs (SPAPs)		
State	**Agency Name**	**Phone Number(s)**
KY	Kentucky ADAP	1-502-564-6539
LA	Louisiana Health Access Program	1-504-931-2642
MA	Prescription Advantage	1-617-222-7529
MD	Maryland AIDS Drug Assistance Program	1-410-767-6535
MD	Maryland Senior Drug Assistance Program	1-410-767-6535
ME	The Low-Cost Drug Program for the Elderly and Disabled	1-866-796-2463
MI	Michigan Drug Assistance Program	1-517-241-3912
MO	MORx	1-573-751-6963
MS	MS ADAP	1-601-362-4879
MT	State of Montana HIV Treatment Program	1-406-444-4744
NC	North Carolina SPAP	1-919-546-1714
ND	North Dakota AIDS Drug Assistance Program (ADAP)	1-701-328-2379
NJ	New Jersey Senior Gold Discount Card Program	1-800-792-9745
NJ	NJPAAD Program	1-800-792-9745
NJ	NJ Aids Drug Distribution Program (NJADDP)	1-877-613-4533
NM	NMMIP SPAP	1-620-793-1121
NV	SRx Program	1-866-303-6323
NV	Disability Rx Program	1-866-303-6323
NY	NYS EPIC	1-800-332-3742
NY	NYS Uninsured Care Programs	1-518-459-1641
OH	Ohio ADAP	1-614-728-2167
OR	CARE Assist	1-971-673-0142
PA	PACE	1-717-787-7313
PA	PACENET	1-717-787-7313

State Pharmaceutical Assistance Programs (SPAPs)		
State	**Agency Name**	**Phone Number(s)**
PA	Special Pharmaceutical Benefits Program/ADAP	1-717-787-7313
PA	Special Pharmaceutical Benefits Program - Mental Health	1-717-783-5797
PR	Puerto Rico Ryan White Part B/ADAP	1-787-765-2929
RI	Rhode Island Pharmaceutical Assistance to the Elderly	1-401-462-0530
SC	South Carolina AIDS Drug Assistance Program (HIV+)	1-803-898-0703
SD	South Dakota Department of Health Ryan White Part B	1-605-773-3523
TN	Ryan White Part B Program for HIV Positive People	1-615-532-2392
TX	Texas Kidney Health Care Program	1-800-222-3986
TX	TX THMP SPAP Program	1-800-255-1090
UT	Utah ADAP	1-801-538-6311
VA	Virginia State Pharmaceutical Assistance Program	1-804-864-7213
VT	ADAP	1-863-7244
VT	Department of Vermont Health Access	1-802-879-5900
WA	Early Intervention Program	1-360-236-3475
WI	SeniorCare	1-608-267-7813
WI	Wisconsin ADAP	1-608-267-6875
WY	WDH, Communicable Disease Treatment Program	1-307-777-5856
Contact information is subject to change throughout the year. For the most up-to-date contact information, visit medicare.gov.		

The AIDS Drug Assistance Program (ADAP)

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

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

SECTION 8 How to contact the Railroad Retirement Board

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

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

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

SECTION 9 "Group insurance" or other health insurance from an employer

If you (or your spouse) get prescription drug benefits through an employer/union or retiree group **other than the County of Orange**, call that group's benefits administrator if you have any questions. You can ask about their employer/retiree health or drug benefits, premiums, or enrollment period. They can also help you determine how your current coverage will work with our plan.

Important Note: Your (or your spouse's) employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enroll in a Medicare Part D program. Call that employer/union benefits administrator to find out whether the benefits will change or end if you or your spouse enroll in a Part D plan.

Chapter 3. Using the plan's coverage for your Part D prescription drugs

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

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

For an explanation of what you pay for Part D drugs, see the next chapter (Chapter 4, *What you pay for your Part D prescription drugs*).

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

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2023 handbook*.) Your Part D prescription drugs are covered under our plan.

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

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

- **You must have a provider (doctor, dentist, or other prescriber) write your prescription.**
- **Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions.** You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- **You must use a network pharmacy to fill your prescriptions.** For more information, see Section 2, *Fill your prescriptions at a network pharmacy or through the plan's home delivery service.*
- **Your drug must be on the plan's Drug List (Formulary).** See Section 3, *Your drugs need to be on the plan's Drug List*.
- **Your drug must be used for a medically accepted indication.** A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Section 3 for more information about a medically accepted indication.

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

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

In most cases, your prescriptions are covered *only* if they are filled at one of the plan's network pharmacies. A network pharmacy is a pharmacy that has agreed to provide your covered

prescription drugs. The term *covered drugs* means all Part D prescription drugs that are covered by the plan.

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

Our network includes pharmacies that offer standard cost sharing, as well as pharmacies that offer preferred cost sharing. You may go to either for your covered prescription drugs. Your cost sharing may be less at preferred pharmacies. Refer to Chapter 4 for more information about cost-sharing amounts.

Section 2.2 Finding network pharmacies

How to find a network pharmacy in your area

To find a network pharmacy, you can choose whichever method is easiest for you:

- Use your *Pharmacy Directory*.
- Visit **optumrx.com** and use the "Pharmacy Locator" tool (found under the "Member Tools" tab).
- Call Optum Rx. Our contact information is on the front cover of this document.

What to do if the pharmacy you have been using leaves the network

We will notify you if your pharmacy leaves the network, and you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can use your *Pharmacy Directory*, get help from Optum Rx, or visit **optumrx.com**.

Specialty pharmacies

Sometimes, prescriptions must be filled at a specialty pharmacy. Specialty pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, contact Optum Rx.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives have access to these Specialty pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the Food and Drug Administration to certain locations or drugs that require extraordinary handling, provider coordination, or education on its use. (Note: This is a rare scenario.)

To locate a specialty pharmacy, call Optum Rx. Our contact information is on the front cover of this document.

Section 2.3 Using the plan's home delivery services

For certain kinds of drugs, you can use the plan's network home delivery services. Generally, the drugs provided through mail order are drugs you take on a regular basis for a chronic or long-term medical condition. To request order forms and information about filling your prescriptions by mail, call Optum Rx or visit our website at **optumrx.com**. If you use a home delivery pharmacy not in the plan's network, you will be responsible for the full cost of the drug.

Usually, prescriptions filled through the home delivery pharmacy will arrive within 7 to 10 business days. Optum Rx will contact you if there will be an extended delay in delivering your medications.

You also have 3 different options to request expedited (fast) delivery of your home delivery prescription using 2nd-day air or overnight shipping (at an additional cost):

- **Online Refills** – Visit **optumrx.com** to submit your order online and choose a shipping method.
- **Optum Rx Member Services** – Use the phone numbers on the front cover of this document to request an alternate shipping method.
- **Mail in the Prescription Order Form** – If you mail in a hard copy of your prescription, you can request expedited delivery by writing your delivery method on the prescription itself, on the order form, or on a separate sheet of paper included with your form.

Note: When ordering online or sending in a form, we will notify you when your order is being processed. If you do not receive notification, or if you have any questions regarding your prescription order, please call Optum Rx using the phone numbers on the front cover of this document.

New prescriptions the pharmacy receives directly from your doctor's office
The pharmacy will automatically fill and deliver new prescriptions it receives from healthcare providers, without checking with you first if you used home delivery services with this plan in the past 12 months.

If you no longer want the pharmacy to automatically fill and ship a new prescription, contact Optum Rx as soon as possible. Our contact information is on the front cover of this document. If you receive a prescription automatically by mail that you do not want, you can request a refund.

If you have not used home delivery with this plan in the last year and you are not signed up for automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a healthcare provider to determine if you want the medication filled and shipped. This will give you the opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form). It will also allow you to cancel or delay the order before it is shipped and you are billed. It is important that you respond each time you are contacted by the pharmacy to let them know what to do with the new prescription and to prevent any delays in shipping. If the pharmacy is unable to contact you, the prescription will be canceled.

Automatic Refills on home delivery prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program, and you can choose which medications get enrolled into the program. Your medications are eligible for the program after the first fill. In other words, once you are close to running out of your medication, you can initiate a refill and enroll in the program at any time by calling the pharmacy or going online at **optumrx.com**. Once your medication is enrolled, we will start to process your next refill automatically when our records show you are close to running out of your drug. The pharmacy will automatically contact you twice within a 30-day period prior to shipping each refill. We will use your preferred method of contact to confirm your order before shipping. This will give you the opportunity to cancel or delay 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. You will need to provide the pharmacy with your preferred method of contact to confirm your order before shipping.

If you choose not to sign up for or use our automatic refill program, you will need to order a refill of your medication at least 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

Note: If you are in a skilled nursing facility or a hospice program, your medications are not eligible for the automatic refill program. In addition, any drugs limited to a 30-day supply cannot be enrolled in the automatic refill program and are not available through home delivery.

To opt out of the automatic refill program, members, prescribers, and/or an authorized representative should contact Optum Rx as soon as possible. Our contact information is on the front cover of this document.

Section 2.4 Getting a long-term supply of drugs

The plan offers a way to get a long-term supply of "maintenance" drugs. Maintenance drugs are drugs you take on a regular basis for a chronic or long-term medical condition. When you get a long-term supply of drugs, your cost sharing may be lower.

You can use the plan's network home delivery services for maintenance medications. Our plan's home delivery service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our home delivery services.

Section 2.5 When you can use an out-of-network pharmacy

Your prescription might be covered in certain situations.

Generally, we only cover drugs filled at an out-of-network pharmacy when you are not able to use a network pharmacy. Below are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out-of-stock at an accessible network retail or mail-service pharmacy (including high-cost and unique drugs).
- You are evacuated or otherwise displaced from your home because of a federal disaster or other public health emergency declaration.

Note: If you go to an out-of-network pharmacy for any of the reasons listed above, the plan will cover up to a one-month supply of the drug.

In these situations, check first with Optum Rx to see if there is a network pharmacy nearby. If we pay for drugs you get at an out-of-network pharmacy, you may still pay more than you would have paid if you had gone to a network pharmacy.

Asking for reimbursement from the plan

If you must use an out-of-network pharmacy to fill a prescription, you may have to pay a higher amount or the full cost rather than paying your normal share. You can ask us to reimburse you for our share of the cost. Chapter 5 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 shows which Part D drugs are covered

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

The drugs on the Drug List are only those covered under this Medicare Part D plan. Earlier in this chapter, Section 1.1 explains Part D drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the 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** – That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.

  – or –

- **Supported by certain reference books** – These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System.

The Drug List includes both brand-name and generic drugs. A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs. Generally, when a generic drug substitute is available, the brand-name drug will no longer be covered.

Section 3.2 There are 4 cost-sharing tiers for drugs on the Drug List.

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

Drug Tier	Helpful Tips
Tier 1	Most generic drugs are listed under Tier 1 and have the lowest copayments.
Tier 2	Drugs listed under Tier 2 generally include preferred brand-name drugs that have lower copayments than non-preferred brand-name drugs.
Tier 3	Drugs listed under Tier 3 generally have higher copayments than preferred brand-name drugs [and may include some specialty or high-cost drugs*].
Tier 4	Specialty or high-cost drugs listed under Tier 4 cost $830 or more for up to a 30-day maximum supply.

* High-Cost (and some Specialty) drugs are those that cost $830 or more for up to a 30-day maximum supply. These types of drugs will be labeled in the *Abridged Formulary* as "NDS" under the "Requirements/Limits" column.

To find out which cost-sharing tier your drug is in, refer to your plan's Drug List.

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

Section 3.3 How to find out if a specific drug is on the Drug List

You have 3 ways to find out:

- Visit **optumrx.com**.
- Check the most recent Drug List we may have sent you in the mail.

  Note: The Drug List we sent includes information for covered drugs most commonly used by our members; however, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Optum Rx to find out if we cover it.
- Call Optum Rx to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Our contact information is on the front cover of this document.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why some drugs have restrictions

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

Note: 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 Types of restrictions

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

Using generic drugs whenever you can

A generic drug works the same as a brand-name drug, but usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies may provide you the generic version.** If your doctor has told us the medical reason that the generic drug will not work for you, we may cover the brand-name drug. Your share of the cost may be greater for the brand-name drug than for the generic drug.

Getting plan approval in advance (prior authorization)

For certain drugs, you or your doctor (or other prescriber) need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. Sometimes, plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes, the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first (step therapy)

This requirement encourages you to try one or more specific drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

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

Section 4.3 How to find out if any of these restrictions apply to your drugs

To find out if any of these restrictions apply to a drug you take or want to take, check the plan's Drug List. For the most up to date information, call Optum Rx or visit **optumrx.com**. Our contact information is on the front cover of this document.

IMPORTANT: Optum Rx has added the restriction of a 30-day maximum supply limit on opioid drugs at both retail and home delivery pharmacies. Our pharmacies will no longer dispense opioid prescriptions for more than a 30-day supply at one time. Optum Rx is making this change to help reduce the risks associated with taking opioid drugs. If you currently have a prescription written for more than a 30-day supply, it is important that you reach out to your prescriber to request a new prescription in order to avoid missing a refill of your medication.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. If there is a restriction on the drug you want to

take, you should contact Optum Rx to learn what you or your provider need to do to your drug covered. If you want us to waive the restriction for you, you will need to use the coverage determination process and ask us to make an exception. We may or may not agree to waive the restriction for you. See Chapter 7 for information about asking for exceptions.

Note: Sometimes, a drug may appear more than once in our Drug List. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your healthcare provider (for instance, 10 mg versus 100 mg; 1 per day versus 2 per day; tablet versus liquid).

SECTION 5 What to do if one of your drugs is not covered in the way you would like it to be covered

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

There may be a prescription drug you are taking, or one you and your doctor think you should be taking, that is not covered in the way you would like it to be. Some example scenarios are listed below.

- The drug you want to take is not covered by the plan. 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 the drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first – to see if it will work – before the plan will cover the drug you want to take. There might also be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
- The drug is covered, but it is in a cost-sharing tier that makes it more expensive than you think it should be. The plan puts each covered drug into one of 5 different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way you would like it to be. Your options depend on what type of problem you have:

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

Section 5.2 What you can do if your drug is not on the Drug List or if it is restricted

You have several options.

- You may be able to get a temporary supply of the drug while you request an exception or until you and your doctor decide it is okay to change to another drug. Only members in certain situations can get a temporary supply.
- 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.

Rules for getting a temporary supply

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

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

1. **The change to your drug coverage must be one of the following types of changes:**
   - The drug you have been taking is no longer on the plan's Drug List.

     – or –
   - The drug you have been taking is now restricted in some way. (Section 4 in this chapter explains restrictions.)
2. **You must be in one of the situations described below:**
   - For those members who were in the plan last year:

     We will cover a temporary supply of your drug during the first 90 days of the calendar year. This temporary supply will be for up to a 30-day supply (less if your prescription is written for fewer days). The prescription must be filled at a network pharmacy.
   - For those members who are new to the plan and are not in a long-term care facility:

     We will cover a temporary supply of your drug during the first 90 days of your enrollment in the plan. This temporary supply will be for up to a 30-day supply (less if your prescription is written for fewer days). The prescription must be filled at a network pharmacy.
   - For those members who are new to the plan and are in a long-term care facility:

     We will cover a temporary supply of your drug during the first 90 days of your enrollment in the plan. The first supply will be for up to a 31-day supply (less if your prescription is written for fewer days). If needed, we will cover additional refills during your first 90 days in the plan.
   - For those members who have been in the plan for more than 90 days, are in a long-term care facility, and need a supply right away:

     We will cover up to a 31-day supply one time (less if your prescription is written for fewer days). This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call Optum Rx. Our contact information is on the front cover of this document.

While you are using a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when the temporary supply runs out. There may be a different drug covered by the plan that will work just as well for you. If not, you and your doctor or other prescriber can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

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

You can change to another drug.

Start by talking with your doctor or other prescriber. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Optum Rx to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor or other prescriber find a covered drug that might work for you.

You can file an exception.

You and your doctor or other prescriber can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. If your doctor or other prescriber says you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule. We will not approve all exception requests.

If you and your doctor or other prescriber want to ask for an exception, Chapter 7 explains what to do. It includes the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What you can do if coverage changes for one of your drugs

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, there may be changes to the Drug List during the year. For example, the plan might:

- **Add or remove drugs** There are many reasons this could happen, including new drugs becoming available, the government giving approval for a new use of an existing drug, a drug being recalled, or a drug being found to be ineffective by the Food and Drug Administration.
- **Move a drug to a lower cost-sharing tier**
- **Remove a restriction on coverage for a drug** - For more information about restrictions on coverage, see Section 4 in this chapter.
- **Replace a brand-name drug with a generic drug**

Note: We must get approval from Medicare for any negative changes we make to the plan's Drug List.

Section 6.2 If coverage changes for a drug you are taking

We will notify you if your drug's coverage has changed.

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

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

When changes to your drug coverage will affect you

If we make any of the following changes to coverage for a drug you are taking, the change will not affect your use of the drug or what you pay as a cost share until January 1 of the next year (if you stay in the plan):

- If we move your drug into a higher cost-sharing tier
- If we put a new restriction on your use of the drug
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it

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

- **If a brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
  - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.

    – or –
  - You and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 7 (What to do if you have a problem or complaint).
- **If a drug is suddenly recalled** because it has been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
  - Your doctor or other prescriber will also know about this change and can work with you to find another drug for your condition.

SECTION 7 Types of drugs not covered by the plan

Section 7.1 Types of drugs we do not cover

Here are 3 general rules about drugs that Medicare drug plans will not cover under Part D:

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

Also, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms

- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products (except prenatal vitamins) and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you receive "Extra Help" from Medicare to pay for your prescriptions, the Extra Help will not pay for drugs not normally covered. Refer to your formulary or call Optum Rx for more information.

Your state Medicaid program *may* cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you.

SECTION 8 Show your member identification (ID) card when you fill a prescription

Section 8.1 Show your ID card

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

Section 8.2 What to do if you do not have your ID card with you

If you do not have your ID card with you when you fill your prescription, ask the pharmacy to call Optum Rx to get the necessary information. Our contact information is on the front cover of this document. 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 for information about how to ask the plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 If you are in a hospital or a skilled nursing facility covered by the plan

If you are admitted to a hospital for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter for information about the rules for getting drug coverage.

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

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

Section 9.2 If you are a resident in a long-term care facility

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

If you need more information about a particular pharmacy within a long-term care facility, please visit **optumrx.com**, check your *Pharmacy Directory*, or contact Optum Rx. Our contact information is on the front cover of this document.

Residents in long-term care facilities that are new members of the plan

If you are a new member and a resident of a long-term care facility, and you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your enrollment. The first fill will be for up to a 31-day supply (less if your prescription is written for fewer days). If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List, or if the plan has any restriction on the drug's coverage, we will cover up to a 31-day supply one time (less if your prescription is written for fewer days).

During the time you are using a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. There may be a different drug covered by the plan that will work just as well for you. In this case, you and your doctor or other prescriber can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. Chapter 7 provides more information about how you can ask for an exception.

Section 9.3 If you are taking drugs covered by Original Medicare

Your enrollment in our Medicare Prescription Drug Plan does not 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 cannot cover it.

If your plan covers Medicare Part B drugs, some drugs may be covered through the County of Orange Medicare Prescription Drug Plan, 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 us or Medicare Part B for the drug.

Section 9.4 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 by November 15 that indicates if your prescription drug coverage is "creditable," along with the choices you have for drug coverage. If the coverage from the Medigap policy is creditable, it means that it has drug coverage that meets Medicare's minimum standards. The notice will also explain how much your premium would be lowered if you removed the prescription drug coverage portion of your Medigap policy. If you did not get this notice, or if you cannot find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 If you are also getting drug coverage from an employer or retiree group plan

If you currently have other prescription drug coverage through your spouse's employer or retiree group, other than with County of Orange, please contact that group's benefits administrator. They can help you determine how your current prescription drug coverage will work with our plan.

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

Special note about creditable coverage

Your previous employer or retiree group should send you a notice that explains if your prescription drug coverage for the next calendar year is "creditable," along with the choices you have for drug coverage. If the coverage from the group plan is creditable, it means that it meets Medicare's minimum standards.

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

Section 9.6 If you are in Medicare-certified hospice

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Drug-use reviews

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

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

- Medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- 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 doctor to correct the problem.

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

We have a program that can help make sure our members safely use their prescription opioid medications or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. If we, in collaboration with your doctors, decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may include:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from certain pharmacies

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from certain doctors
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you have had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake, if you disagree with our determination that you are at risk for prescription drug misuse, or if you disagree with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 7 for information about how to ask for an appeal.

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

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

Our Medication Therapy Management (MTM) Program helps our members with special situations. For example, some members have several complex medical conditions, may need to take many drugs at the same time or could have very high drug costs.

This program is free to members and helps make sure our members are using the drugs that work best to treat their medical conditions. It also helps us identify possible medication errors.

Your pharmacist or other healthcare professional will provide you with a comprehensive review of all your medications. Talk with them about how best to take your medications, your medication costs, and any concerns or questions you have about your prescription or over-the-counter medications. You will receive a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, as well as space for you to take notes or write down any follow-up questions. You will also get a personal medication list that includes all medications you are taking and why you take them.

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

We will automatically enroll you in the program and send you information if you meet the criteria. If you decide not to participate, please notify us and we will withdraw your participation in the program.

Chapter 4. What you pay for your Part D prescription drugs

SECTION 1 Introduction

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

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use **drug** in this chapter to mean a Part D prescription drug. As explained in Chapter 3, some drugs are covered under Original Medicare or are excluded by law.

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

- **The plan's Drug List (Formulary)**
  - The Drug List shows which drugs are covered for you.
  - It also shows which cost-sharing tier the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Optum Rx. Our contact information is on the front cover of this document. You can also find the Drug List on **optumrx.com**.
- **Chapter 3 of this document-** Chapter 3 provides details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. It also explains which types of prescription drugs are **not** covered by our plan.
- **The plan's Pharmacy Directory -** In most situations, you must use a network pharmacy to get your covered drugs. The Pharmacy Directory includes a list of pharmacies in the plan's network.
  - See Chapter 3 for details or visit **optumrx.com** and use the "Pharmacy Locator" tool (found under the "Member Tools" tab).

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 The 4 drug payment stages

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

As shown in the table below, there are 4 "drug payment stages" for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind that you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 Yearly Deductible	**This plan does NOT have a Deductible. This stage does not apply to you.**
Stage 2 Initial Coverage	During this stage, the plan pays its share of the cost and you pay your share of the cost of your drugs. Your share of the cost is shown in a section later in this chapter titled *The Initial Coverage Stage*. You stay in this stage until your year-to-date Part D out-of-pocket costs (your payments) reach a total of $7,400. Medicare sets this total and the rules for counting costs toward this amount. Your enhanced benefits include a plan-specific out-of-pocket maximum of $4,100. Once you reach your enhanced plan out-of-pocket maximum of $4,100, the plan will pay **all** of your drug costs for the remainder of the year.
Stage 3 Coverage Gap	**This plan does NOT have a Coverage Gap. This stage does not apply to you.**
Stage 4 Catastrophic Coverage	Most members do not reach the Catastrophic Coverage Stage because your enhanced benefits include a plan-specific out-of-pocket maximum of $4,100. Once you reach your out-of-pocket maximum of $4,100, the plan will pay **all** of your drug costs for the remainder of the year. If you **do** reach the calendar year maximum (including manufacturer discounts) of $7,400, you will pay whichever is the higher amount between the following [(not to exceed the standard copayment amount during the Initial Coverage Stage)]: • 5% coinsurance **or** • $4.15 copayment for covered generic drugs (including brand drugs treated as generics) • $10.35 copayment for all other covered drugs

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

Section 3.1 We send you a monthly report called the *Explanation of Benefits*.

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 a pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are 2 types of costs we keep track of:

- How much you have paid - This is called your **out-of-pocket** cost.
- Your **total drug costs** - This is the total amount that you have paid plus what others have paid on your behalf and what the plan has paid.

Our plan will send you a written report called the *Explanation of Benefits* (or EOB) when you have had one or more prescriptions filled. It includes:

- **Information for that month** - This report provides payment details about the prescriptions you have filled during the previous month. It shows total drugs costs for the month, what the plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1** - This is called “year-to-date” information. It shows your total drug costs and payments for your drugs since the year began.
- Drug price information. This information will display cumulative percentage increases for each prescription claim.
- Available lower cost alternative prescriptions. This will include information about other drugs with lower cost sharing for each prescription claim that may be available.

Your *EOB* is also available electronically through the Optum Rx member portal. If you choose to do this, you will get an email each month when your *EOB* Statement is available to view online.

Just follow these 4 easy steps:

1. Log on to the Optum Rx member portal at optumrx.com/public/landing
2. Click on the My profile tab
3. Select Communication preferences
4. Update your option to Paperless for the *EOB*

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and 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.** To make sure we know about prescriptions you are filling and what you are paying, show your plan ID card every time you get a prescription filled.

Make sure we have the information we need. There are times you pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-

of-pocket costs, you can send us copies of receipts for drugs you have purchased. If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5 of this document.

Below are types of situations where you may want to send us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase a covered drug at a network pharmacy at a special price
- When you make a copayment for a drug that is provided under a drug manufacturer patient assistance program
- Any time you purchase a covered drug at an out-of-network pharmacy, or other times you pay full price for a covered drug under special circumstances

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

Check the written or electronic report we send you. If you receive an *Explanation of Benefits* in the mail or online, please look it over to be sure the information is complete and correct. If you think something is missing from the report or you have any questions, call Optum Rx. Our contact information is on the front cover of this document. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for County of Orange Medicare Prescription Drug Plan

Section 4.1 You do not pay a deductible for your Part D drugs

There is no deductible for this plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See the next section for information about your coverage in the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

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

You begin in the Initial Coverage Stage when you fill your first prescription of the year. During this phase, the plan pays its share of the cost of your covered prescription drugs, and you pay your share of the cost. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 4 cost-sharing tiers.

Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

Drug Tier	Helpful Tips
Tier 1	Most generic drugs are listed under Tier 1 and have the lowest copayments.
Tier 2	Drugs listed under Tier 2 generally include preferred brand-name drugs that have lower copayments than non-preferred brand-name drugs.
Tier 3	Drugs listed under Tier 3 generally have higher copayments than preferred brand-name drugs and may include some specialty or high-cost drugs*.
Tier 4	Specialty or high-cost drugs listed under Tier 4 cost $830 or more for up to a 30-day maximum supply.

* High-Cost (and some Specialty) drugs are those that cost $830 or more for up to a 30-day maximum supply. These types of drugs will be labeled in the *Abridged Formulary* as "NDS" under the "Requirements/Limits" column.

To find out which cost-sharing tier your drug is in, refer to your plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from a network pharmacy or a home delivery pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3. You may also visit **optumrx.com** and refer to the "Pharmacy Locator" tool (found under the "Member Tools" tab).

Section 5.2 Your costs for a 30-day and 90-day supply of a drug

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

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

  – or –

- **Coinsurance** - This means you pay a percent of the total cost of the drug each time you fill a prescription.

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

Your share of the cost when you get Covered Part D prescription drugs

	Retail Network Pharmacy 30-day supply	Retail Network Pharmacy 90-day supply	The Plan's Home Delivery Service
Cost-Sharing Tier 1 (Generic drugs)	20% coinsurance	20% coinsurance	20% coinsurance
Cost-Sharing Tier 2 (Preferred Brand drugs)	25% coinsurance	25% coinsurance	25% coinsurance
Cost-Sharing Tier 3 (Non-Preferred Brand drugs)	30% coinsurance	30% coinsurance	30% coinsurance
Cost-Sharing Tier 4 (High-Cost drugs *)	30% with $150 max	30% with $450 max	30% with $450 max (up to a 90-day supply)
* High-Cost drugs are those that cost $830 or more for up to a 30-day maximum supply.			

Section 5.3 You stay in the Initial Coverage Stage until your Part D out-of-pocket costs reach $7,400 for the calendar year.

Since your enhanced plan has a lower out-of-pocket maximum of only $4,100, you will likely never reach the Part D out-of-pocket maximum of $7,400 and enter the Catastrophic payment stage during the year. Once you reach your enhanced plan out-of-pocket maximum of $4,100, the plan pays **all** of the costs of your drugs for the remainder of the year.>

The *Explanation of Benefits* we send you helps you keep track of how much you and the plan have spent for your drugs during the year. This report provides payment details about prescriptions you have filled during the previous month.

If you **do** reach the maximum out-of-pocket Part D limit of $7,400 for the year, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Section 5.4 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 for certain drugs

Typically, you pay a copay to cover a full month's supply of a covered drug; however, your doctor can prescribe less than a month's supply of a drug. There may be times when you want to ask your doctor to prescribe less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees, you will not have to pay for the full month's supply **for certain drugs**.

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

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. Because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive. For example:
  - If the copay for your drug for a full month's supply (a 30-day supply) is $30, this means the amount you pay per day for your drug is $1. If you receive a 7-day supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.
  - You should not have to pay more per day just because you begin with less than a month's supply. From the example above, if you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7-day supply runs out, and you receive a second prescription for the rest of the month (or 23 days more of the drug), you will still pay $1 per day, or $23. Your total cost for the month will be $7 for your first prescription and $23 for your second prescription, for a total of $30 – the same as your copay would be for a full month's supply.

Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply (depending on the drug dispensed).

SECTION 6 There is no coverage gap for County of Orange Medicare Prescription Drug Plan

Section 6.1 You do not have a coverage gap for your Part D drugs

There is no coverage gap for this plan. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

When your Part D out-of-pocket costs reach $7,400, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Since your enhanced plan has a lower out-of-pocket maximum of only $4,100, you will likely never reach the Part D out-of-pocket maximum of $7,400 and enter the Catastrophic payment stage during the year. Once you reach your enhanced plan out-of-pocket maximum of $4,100, the plan will pay **all** of the costs of your drugs for the remainder of the year.

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

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When your Part D out-of-pocket costs reach $7,400, you move on to the Catastrophic Coverage Stage.

Below are the Medicare rules we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments <u>are included</u> in your out-of-pocket costs.

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

- 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* 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 Medicare's "Extra Help" program, by AIDS Drug Assistance Programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included, but the amount the plan pays for your generic drugs is *not* included.

Moving on to the Catastrophic Coverage Stage

- Once you (or those paying on your behalf) spend a total of $7,400 for Part D out-of-pocket costs during the calendar year, you move to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs.

When you add up your out-of-pocket costs, you **<u>cannot include</u>** any of these types of payments for prescription drugs:

- The amount you may pay for your monthly premium
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage
- Non-Part D excluded drugs
- Prescription drugs covered by Part A or Part B
- Drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan
- Drugs not normally covered in a Medicare Prescription Drug Plan
- Payments made by the plan for your brand or generic drugs while in the coverage gap

- Payments for your drugs that are made by group health plans including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Administration
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, workers' compensation)

Reminder: If any other organization, such as the ones listed above, pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Optum Rx to let us know. Our contact information is on the front cover of this document.

Important note: This plan has a plan-specific out-of-pocket maximum, which differs from the Medicare Part D limit. Medicare sets rules, as stated above, about what can and cannot be included toward the Part D limit. Our plan sets different rules as to what does and does not count toward out-of-pocket costs to reach the plan-specific out-of-pocket maximum of $4,100. Refer to your *Explanation of Benefits* to determine which costs have been applied to your maximum out-of-pocket limit.

Keeping track of your out-of-pocket total

- **We will help you**. The *Explanation of Benefits* report we send to you includes the current amount of your out-of-pocket costs. This report will let you know when you reach a total of $4,100 in out-of-pocket costs for the year.

SECTION 7 The Catastrophic Coverage Stage

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

You qualify for the Catastrophic Coverage Stage when your Part D out-of-pocket costs reach $7,400 for the calendar year. Once you are in the Catastrophic Coverage Stage, you stay in this payment stage until the end of the calendar year.

Because your enhanced benefits include a plan-specific out-of-pocket maximum of $4,100, most members do not reach the Catastrophic Coverage Stage. Once you pay the maximum out-of-pocket costs of $4,100, the plan will pay **all** of the cost for your drugs. If you **do** reach the Part D out-of-pocket limit of $7,400 before your plan-specific maximum of $4,100, you enter the Catastrophic Coverage Stage, and your share of the cost for a covered drug will be either coinsurance or a copayment, as shown below.

Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the higher amount (not to exceed the standard copayment amount during the Initial Coverage Stage):

Coinsurance of 5% of the cost of the drug; or

- $4.15 copayment for a generic drug or a drug that is treated like a generic
  $10.35 copayment for all other drugs

Our plan pays the rest of the cost.

SECTION 8 What you pay for a vaccine depends on how and where you get it

Section 8.1 Our plan has separate coverage for the vaccine and for the cost of giving you the vaccine.

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

There are 2 parts to our coverage of vaccines:

- Cost of the vaccine - The vaccine is a prescription medication.
- Cost of giving you the vaccine - This is sometimes called the “administration” of the vaccine.

What you pay for a vaccine

What you pay for a vaccine depends on three things:

- The type of vaccine (what you are being vaccinated for)
  - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s Drug List.
- Where you get the vaccine
- Who gives you the vaccine

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

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

To show how this works, here are three common ways you might get a vaccine.

Situation 1

You buy the vaccine at a pharmacy and get your vaccine at a network pharmacy. Whether or not you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccine.

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and administration of the vaccine.

Situation 2

You get the vaccine at your doctor’s office.

- When you get the vaccine, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this document (Asking the plan to pay its share of the costs for covered drugs).

- You will be reimbursed the amount you paid minus your normal coinsurance or copayment for the vaccine (including administration) and any difference between the amounts the doctor charges and what we normally pay. If you receive Extra Help, we will reimburse you for this difference.

Situation 3

You buy the vaccine at a pharmacy and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this document.
- You will be reimbursed the amount charged by the doctor minus the amount for administering the vaccine and any difference between the amounts the doctor charges and what we normally pay. If you receive Extra Help, we will reimburse you for this difference.

Section 8.2 You may want to call Optum Rx before you get a vaccine

The rules for coverage of vaccines are complicated. We are here to help. We recommend that you call Optum Rx first whenever you are planning to get a vaccine. Our contact information is on the front cover of this document.

- We can tell you about how your vaccine is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 9 The Part D late enrollment penalty

Section 9.1 What the Part D late enrollment penalty is

You may pay a financial penalty (additional monthly amount) if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or if you went 63 days in a row or more without creditable prescription drug coverage. "Creditable prescription drug coverage" is drug coverage that meets Medicare's minimum standards.

The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible. You may owe a late enrollment penalty if you went without drug coverage for any continuous period of 63 days or more after you were first eligible for Part D. If the penalty is assessed, you will have to pay the additional amount as long as you have Medicare prescription drug coverage, and the amount may be adjusted each year.

The additional penalty amount is added to your monthly premium. Members who choose to pay their premium every three months will have the penalty added to their three-month premium. When you first enroll in our plan, we let you know the amount of the penalty.

If you receive “Extra Help” from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will **not** pay a late enrollment penalty, even if you go without “creditable” prescription drug coverage for 63 or more days in a row. If you no longer receive Extra Help, you will be responsible for paying the late enrollment penalty amount.

Section 9.2 How the Part D late enrollment penalty is calculated

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

- Count the number of full months that you delayed enrolling in a Medicare drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage (if the break in coverage was 63 days or more in a row). For every month you did not have creditable coverage, the penalty is 1% of the average monthly premium for Medicare Prescription Drug Plans from the previous year. For example, if you go 14 months without coverage, the penalty will be 14%.
- Medicare determines the amount of the average monthly premium for Medicare Prescription Drug Plans in the nation from the previous year. For 2022, this average premium amount was $33.37. This amount may change for 2023.
- To get your monthly penalty, multiply your penalty percentage and the average monthly premium, and then round it to the nearest 10 cents. In the example here, it would be 14% times $33.37, which equals $4.62. This rounds to $4.60. This amount would be added to the monthly premium.

There are 3 important things to note about the monthly late enrollment penalty:

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

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

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

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

- You were without creditable coverage for less than 63 days in a row.
- You receive Extra Help from Medicare.
- You already have prescription drug coverage at least as good as Medicare’s standard drug coverage. Medicare calls this **creditable drug coverage**.
    - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your

human resources department to find out if your current drug coverage is at least as good as Medicare's.

Note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state you had creditable prescription drug coverage that was expected to pay as much as Medicare's standard prescription drug plan pays.

- The following are **not** considered creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For more information about creditable coverage, look in your *Medicare & You* handbook or call Medicare toll free at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

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

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about it. Generally, you must ask for this review within 60 days from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Optum Rx at 1-855-235-0294 **,** TTY 711, Monday –Friday, 8 a.m. –8 p.m. local time, except holidays, to find out more about how to do this.

Important: If applicable, do not stop paying your Part D late enrollment penalty while you are waiting for a decision about it. If you do, you could be disenrolled for failure to pay your plan premium.

SECTION 10 Extra Part D payment amounts due to income

Section 10.1 Rules about the extra Part D payment amounts due to income

Most people pay a standard monthly Part D premium; however, some people pay an extra amount because of their yearly income. If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. If your income is $91,000 or more for an individual (or married individuals filing separately) or $182,000 or more for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you are required to pay an extra amount, the Social Security Administration (not your Medicare plan) will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your benefit check from Social Security, the Railroad Retirement Board, or the Office of Personnel Management. The amount will be withheld no matter how you usually pay your plan premium, unless your monthly benefit is not enough to cover the extra amount owed. If your benefit check is not enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 10.2 What you can do if you disagree about paying an extra Part D amount

If you disagree with paying an extra amount due to your income, you can ask the Social Security Administration 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 10.3 What happens if you do not pay the extra Part D amount

If you are required to pay the extra amount and do not pay it, the Centers for Medicare & Medicaid Services will disenroll you, and you will lose prescription drug coverage.

The prescription drug coverage is offered in conjunction with your Wellwise Retiree PPO coverage. If you choose a different Medicare Prescription Drug Plan other than the County of Orange EGWP you will automatically be disenrolled from Wellwise Retiree PPO and defaulted to Sharewell Retiree when your new plan’s coverage begins, and ineligible to change plans until next open enrollment or qualified life event.

Chapter 5. Asking the plan to pay its share of the costs for covered drugs

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

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

Sometimes, when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back. Paying you back is often called "reimbursing" you. Asking for reimbursement in the first 3 examples below are types of coverage decisions. For more information about coverage decisions, go to Chapter 7 of this document.

Here are examples of situations in which you may need to ask our plan to pay you back:

1. **When you use an out-of-network pharmacy to get a prescription filled**
   - If you go to an out-of-network pharmacy and try to use your plan member ID card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please call Optum Rx for more information. Our contact information is on the front cover of this document.
   - Save your receipt and prescription label (usually attached to the pharmacy bag), along with all necessary documentation needed to accurately process the claim. Send a copy to us when you ask us to pay you back for our share of the cost.

2. **When you pay the full cost for a prescription because you do not have your plan member ID card with you**
   - If you do not have your ID card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the plan to get your member information, but there may be times when you need to pay if you do not have your card.
   - Save your receipt and prescription label (usually attached to the pharmacy bag), along with all necessary documentation needed to accurately process the claim. Send a copy to us when you ask us to pay you back for our share of the cost.

3. **When you pay the full cost for a prescription in other situations**
   - You may pay the full cost of the prescription because you find that the drug is not covered for some reason.
     - For example, the drug may not be on the plan's Drug List (Formulary), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost.
   - Save your receipt and prescription label (usually attached to the pharmacy bag), along with all necessary documentation needed to accurately process the claim. Send a copy to us when you ask us to pay you back for our share of the costs. In some situations, we may need to get more information from your doctor in order to pay you back.

All 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 (What to do if you have a problem or complaint) has more information about how to file an appeal.

SECTION 2 How to ask us to pay you back

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

Send us your request for payment, along with your receipt and prescription label (usually attached to the pharmacy bag), to show the payment you have made. It is a good idea to make a copy of the documentation for your records.

To make sure we get all the information we need to make a decision, you can fill out our claim form to ask for payment. You do not have to use the form, but it helps us process the information faster. Either download a copy of the form from **optumrx.com** or call Optum Rx and ask for the form. Our contact information is on the front cover of this document.

Mail your request for payment, your receipt, and your prescription label to us at this address:

Optum Rx
Attn: Manual Claims
PO Box 650287
Dallas, TX 75265-0287

Be sure to contact Optum Rx if you have any questions. You can also call if you want to give us more information about a request for payment you have already sent us.

SECTION 3 We will consider your request for payment

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 more information; otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail you reimbursement for all but your share within 14 days. Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs.
- If we decide that the drug is **not** covered, or you did **not** follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains why we are not sending the payment you requested. It will also explain your right to appeal the decision.

Section 3.2 If we tell you that we will not pay for the drug, you can file an appeal

If you think we made a mistake, you can file an appeal. If you file an appeal, it means you are asking us to change our decision.

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

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

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

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

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

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

- If applicable, when you are in the Deductible Stage or Coverage Gap Stage, you can buy your drug at a network pharmacy for a price that is lower than our price.
  - For example, a pharmacy might offer a special price on a drug, or you may have a discount card that is outside the plan benefits that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List (Formulary).
- Save your receipt and send a copy to us so that we can count your out-of-pocket expenses toward qualifying you for the Catastrophic Coverage Stage.

Note: If you are in the Deductible Stage or Coverage Gap Stage, we may not pay for any share of these drug costs, but sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage sooner.

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

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

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

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

Since you are not asking for payment in the 2 cases described above, these situations are not considered coverage decisions; therefore, you cannot file an appeal if you disagree with our decision.

Chapter 6. Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you.

Our plan has free interpreter (translation) services available to answer questions from non-English-speaking members. Optum Rx has special telephone equipment that is used for people who have difficulty hearing or speaking. Upon request, we can also give you information in braille, 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 request information in an alternate format, call Optum Rx. Our contact information is on the front cover of this document.

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

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

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

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

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

How we protect the privacy of your health information

- We make sure unauthorized people do not see or change your records.
- In most situations, if we give your health information to anyone who is not providing or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have authorized in writing to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - 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, they will do so according to federal statutes and regulations.

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

You have the right to look at and receive copies of your records that we keep on file. 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 records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Optum Rx. Our contact information is on the front cover of this document.

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. If you want any of the following kinds of information, call Optum Rx:

- **Information about our plan** - To request that a copy of plan information be mailed to you, contact Optum Rx.
- **Information about our network pharmacies** - You have the right to get information from us about the pharmacies in our network. For an up to date list of pharmacies in the plan's network, visit **optumrx.com** and use the "Pharmacy Locator" tool (found under the "Member Tools" tab). For more detailed information about our pharmacies, you can call Optum Rx.
- **Information about coverage and rules you must follow when using your coverage** - To get details on your Part D prescription drug coverage, see Chapters 3 and 4 of this document, plus the plan's Drug List (Formulary). These chapters, together with the Drug List, tell you what drugs are covered and explain rules you must follow and restrictions to your coverage for certain drugs. If you have questions about the rules or restrictions, call Optum Rx.
- **Information about why something is not covered and what you can do about it** - If a Part D drug is not covered for you or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation, even if you received the drug from an out-of-network pharmacy.

If you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change our decision. You can ask us to change the decision by filing an appeal. For details on what to do if something is not covered for you in the way you think it should be, see Chapter 7 of this document. It provides details about how to file an appeal if you want us to change our decision. Chapter 7 also explains how to make a complaint about quality of care, waiting times, and other concerns. If you want to ask our plan to pay our share of the cost for a covered Part D prescription drug, see Chapter 5 of this document.

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

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

Sometimes, people become unable to make healthcare 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 if you want to, you can:

- Fill out a written form to **give someone 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 you use in these situations to give your directions in advance 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 healthcare** are examples of advance directives.

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind 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. If you have authorized someone to make decisions on your behalf, give a copy of the form to the person you have authorized on your behalf, too. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

Remember, it is your choice whether or not 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 to do if your instructions are not followed

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

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this document explains what to do. It provides details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. Whatever you do, **we are required to treat you fairly.**

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

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

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

If it is about something else

If you think you have been treated unfairly or your rights have not been respected, and it is **not** about discrimination, you can get help dealing with the problem you have by calling:

- **Optum Rx Member Services** - Our contact information is on the front cover of this document.
- **Your State Health Insurance Assistance Program** - For details about this organization and how to contact it, refer to Chapter 2 of this document.
- **Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

Section 1.8 How to get more information about your rights

There are several ways to get more information about your rights:

- **Call Optum Rx.** Our contact information is on the front cover of this document.
- **Call your State Health Insurance Assistance Program.** For details about this organization and how to contact it, refer to Chapter 2 of this document.
- **Contact Medicare.**
  - Visit medicare.gov to read or download the publication "Your Medicare Rights & Protections."
  - Call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.

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

Section 2.1 Your responsibilities

Things you need to do as a member of the plan are listed below. If you have any questions, call Optum Rx. We are here to help.

Get familiar with your covered drugs and the rules you must follow to get these covered drugs. Use this *Evidence of Coverage* document to learn what is covered for you and the rules you need to follow to get your covered drugs.

- Chapters 3 and 4 provide details about your coverage for Part D prescription drugs.

If you have other prescription drug coverage besides our plan, you are required to tell us. Please call 1-855-235-0294 to let us know.

- We are required to follow rules set by Medicare to make sure you are using all of your coverage in combination when you get your covered drugs from our plan. This is called **coordination of benefits** because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We will help you.

Tell your doctor and pharmacist that you are enrolled in our plan. Show your plan ID card whenever you get your Part D prescription drugs.

Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.

- To help your doctors and other healthcare providers give you the best care, learn as much as you can about your health problems. Give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
- If you have questions, be sure to ask. Your doctors and other healthcare providers should explain things in a way you can understand. If you ask a question and you do not understand the answer you are given, ask again.

Pay what you owe. As a plan member, you are responsible for these payments:

- You must pay your plan premiums (if applicable) to continue being a member of our plan. In addition, 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).
- For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (fixed amount) or coinsurance (percentage of total cost). Chapter 4 explains what you must pay for your Part D prescription drugs.
- If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- If you are required to pay a late enrollment penalty, you must pay it. You may be disenrolled if you stop paying it.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount to remain a member of the plan.

Tell us if you move. If you are going to move, contact County of Orange immediately to update your records. This will ensure you receive all necessary correspondence.

Call Optum Rx for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.

- Phone numbers and hours for Optum Rx are on the front cover of this document.
- For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

MAKING COMPLAINTS 90

BACKGROUND

SECTION 1 Introduction

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

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you will try an informal approach first and **call Optum Rx**. Our contact information is on the front cover of this document. We will work with you to try to find a solution to your problem.

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

2 formal processes for dealing with problems

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

This chapter explains 2 types of formal processes for handling problems:

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

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

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

Section 1.2 Legal terms

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

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

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms for the situation you are in. Knowing these terms may help you communicate more clearly and accurately when you deal with your problem. They may also help you get the right information or help for your situation. This is why we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations not connected to us

Section 2.1 Where to get more information and personalized assistance

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

You can get help from an independent government organization

We are always available to help you, but in some situations, you may also want help or guidance from someone who is not connected to us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected to our plan or to 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 have. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. You can find their phone numbers in Chapter 2 of this document.

You can also get help and information from Medicare

For more information and help with handling a problem, you can also contact Medicare:

- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.
- **Visit medicare.gov.**

SECTION 3 How to know which process to use to deal with your problem

Section 3.1 When to use the process for coverage decisions and when to use the process for filing complaints

If you have a problem or concern and you want to do something about it, you do not need to read this whole chapter. You only need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE.**

Is your problem or concern about your benefits or coverage?

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

Yes My problem is about benefits or coverage.

Go to **Section 4** of this chapter **(A guide to the basics of coverage decisions and appeals)**.

No My problem is **not** about benefits or coverage.

Skip ahead to **Section 7** at the end of this chapter **(How to make a complaint about quality of care, waiting times, member 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 filing appeals: the big picture

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage, or about the amount we will pay for your prescription drugs. We make a coverage decision for you whenever you fill a prescription at a pharmacy.

Usually, there is no problem. We decide the drug is covered and pay our share of the cost. But in some cases, we might decide the drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can file an appeal.

Filing an appeal

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

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

coverage decision. 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.

If we 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 our plan. If you are not satisfied with the decision for the Level 2 Appeal, you may be able to continue through several more levels of appeal.

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

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

- You can **call Optum Rx**. Our contact information is on the front cover of this document.
- To **get free help from** your State Health Insurance Assistance Program (SHIP). You can find their contact information in Chapter 2 of this document.
- You should **consider getting your doctor or other prescriber involved**, if possible, especially if you want a fast (expedited) decision. In most situations involving a coverage decision or appeal, your doctor or other prescriber must explain the medical reasons that support your request. Your doctor or other prescriber cannot request every appeal. They can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative." (See next item for information about representatives.)
- 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 to file an appeal.
    - There may be someone who is already legally authorized to act as your representative under state law.
    - If you want a friend, relative, your doctor or other prescriber, or another person to be your representative, call Optum Rx and ask for the Appointment of Representative form to give that person permission to act on your behalf. The form must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.
- You also have the right to **hire a lawyer to act for you**. You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify; however, **you are not required to hire a lawyer to ask for any kind of coverage decision or to appeal a decision.**

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

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

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

As a member of our plan, your benefits include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's Drug List (Formulary) and they are medically necessary for you (as determined by your primary care doctor or other provider).

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the Drug List, rules and restrictions on coverage, and cost information, see Chapter 3 (Using the plan's coverage for your Part D prescription drugs) and Chapter 4 (What you pay for your Part D prescription drugs) of this document.

Part D coverage decisions and appeals

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

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

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's Drug List
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us if a drug is covered for you and whether or not you satisfy any applicable coverage rules (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment

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

This section explains both how to ask for coverage decisions and how to request an appeal. Use the following chart to help you determine which part has information for your situation.

If you are in this situation:	This is what you can do:
You need a drug that is not on our Drug List or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. This is a type of coverage decision. Start with **Section 5.2** of this chapter.
You want us to cover a drug on our Drug List, and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a coverage decision. Skip ahead to **Section 5.4** of this chapter.
You want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. This is a type of coverage decision. Skip ahead to **Section 5.4** of this chapter.
We already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can file an appeal. This means you are asking us to reconsider. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Exceptions

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

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request.

Below are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make.

1. Covering a Part D drug for you that is not on our plan's Drug List (Formulary)

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

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to the drug. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. For more information about excluded drugs, go to Chapter 3 of this document.

2. **Removing a restriction on the plan's coverage for a covered drug** - There are extra rules or restrictions that apply to certain drugs on the plan's Drug List. For more information, go to Chapter 3 of this document.

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception**.

   - The extra rules and restrictions on coverage for certain drugs may include:
     - **Using the generic version** of a drug instead of the brand-name drug
     - **Getting plan approval in advance** before we will agree to cover the drug for you (sometimes called "prior authorization")
     - **Trying a different drug first** before we will agree to cover the drug you are asking for (sometimes called "step therapy")
     - **Quantity limits** - For some drugs, there are restrictions on the amount of the drug you can have.
   - If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier** - Every drug on the plan's Drug List is in a cost-sharing tier. In general, the lower the cost-sharing tier, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower price for a covered drug is sometimes called asking for a **tier exception**.

   - If your drug is in Tier 3 and there is an alternative drug available in Tier 1 or Tier 2, you can ask us to cover your drug at the cost-sharing amount that applies to drugs in the lower tier. This would lower your share of the cost for the drug. Tier exceptions are not permitted for any drug in the high-cost drug tier (Tier 4).
     - If your drug is a biological product, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.
     - If your drug 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 you drug 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 request for a tiering exception, and there is more than one lower cost-sharing tier with alternative drugs you cannot 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 for requesting an exception.

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber right away 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 tier exception, we will generally *not* approve your request for an exception unless all alternative drugs in the lower cost-sharing tiers do not work as well for you or likely to cause an adverse reaction or other harm.

Our plan can say yes or no to your request.

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

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

Step 1: You ask our plan to make a coverage decision about the drug(s) or payment you need.

What to do:

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For details about contacting us, go to Chapter 2 of this document.
- **You, your doctor, or someone else who is acting on your behalf can ask for a coverage decision.** Section 4 of this chapter explains how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug**, start by reading Chapter 5 of this document (Asking the plan to pay its share of the costs for covered drugs). Chapter 5 describes the situations in which you may need to ask for reimbursement and how to do so.
- **If you are requesting an exception, provide the “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. We call this the “doctor’s statement.” Your doctor or other prescriber can fax or mail the statement to our plan, or they can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 5.2 and 5.3 for more information about exception requests.
- **We will review any written request**, including a request submitted on the Coverage Determination Request Form, which is available on our website.

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

Legal Terms	A **fast decision** is called an **expedited decision**.

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

- To get a fast decision, you must meet 2 requirements:
  - You are asking for a drug you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a drug you are 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 decision, we will automatically agree to give you a fast decision.
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - If your doctor or other prescriber asks for a fast decision at this point, we will automatically give you a fast decision.
  - The letter will also explain how you can file a complaint about our decision. It explains how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.

Step 2: Our plan considers your request and we give you our answer.

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires it.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we explain more about this review organization and what happens at Appeal Level 2.

- **If our answer is yes** to part or all of what you requested, we must provide the coverage we have agreed to within 24 hours after we receive your request or doctor's statement.
- **If our answer is no** to part or all of what you requested, we will send you a written statement that explains why.

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

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

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we explain more about this review organization and what happens at Appeal Level 2.
- **If our answer is yes** to part or all of what you requested, we must send 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.

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

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

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

Legal Terms	When you start the appeals process by filing an appeal, it is called the **first level of appeal** or a **Level 1 Appeal**. An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination**.

Step 1: You contact our plan and file your **Level 1 Appeal**.
What to do:

- To start your appeal, you, your representative, or your doctor or other prescriber must contact our plan.
- For details on how to reach us by phone, fax, or mail for any purpose related to your `

File your appeal in writing by sending us a signed request.

- If you are asking for a standard appeal, file your appeal by sending us a written request.
- If you are asking for a fast appeal, you can appeal in writing or by calling Optum Rx. Our contact information is on the front cover of this document.
- **We will review any written request**, including a request submitted on the Coverage Determination Request Form, which is available at **optumrx.com**.
- **You must file your appeal within 60 calendar days** from the date on the written notice we sent you with our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal.
- You can ask for a copy of the information we reviewed in your appeal and add more information to support your appeal.
  - You have the right to ask us for a copy of the information we reviewed regarding your appeal. We are allowed to charge a fee for copying the information and sending it to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal."

Legal Terms	A **fast appeal** is also called an **expedited appeal**.

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

Step 2: Our plan considers your appeal, and we give you our answer.

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

Deadlines for a fast appeal

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

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

- **If our answer is yes** to part or all of what you requested, we must provide the coverage we have agreed to within 72 hours.
- **If our answer is no** to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a standard appeal

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

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

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by filing another appeal.
- If you decide to file another appeal, it means your appeal is going on to Level 2 of the appeals process.

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

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

Legal Terms	The formal name for the **Independent Review Organization** is the **Independent Review Entity**. It is sometimes called the **IRE**.

Step 1: To file a **Level 2 Appeal**, you must contact the Independent Review Organization and ask for a review of your case.

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

Step 2: The Independent Review Organization reviews your appeal and gives you an answer.

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

Deadlines for fast appeal at Level 2

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

Deadlines for standard appeal at Level 2

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

What if the review organization says no to your appeal?

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

To continue and file another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot file another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

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

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

SECTION 6 Taking your appeal to Level 3 and beyond

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

This section only applies to you if you have filed a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets a minimum level, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, 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, the last 3 levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the federal government** will review your appeal and give you an answer. This judge is called an **Administrative Law Judge**.

- **If the answer is yes**, the appeals process is over. What you asked for in the appeal has been approved.
- **If the answer is no**, the appeals process may (or may not) be over.
  - If you decide to accept this decision, 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.
  - Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

- **If the answer is yes**, the appeals process is over. What you asked for in the appeal has been approved.
- **If the answer is no**, the appeals process may (or may not) be over.
  - If you decide to accept this decision, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

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

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

Section 7.1 The kinds of problems handled by the complaint process

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

Below are examples of the kinds of problems handled by the complaint process. If you have any of these kinds of problems, you can "file a complaint."

Complaint	Example
Quality of your medical care	Are you unhappy with the quality of the care you received?
Respecting your privacy	Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor member service, or other negative behaviors	Has someone been rude or disrespectful to you? Are you unhappy with how our Member Services treated you? Do you feel you are being encouraged to leave the plan?
Waiting times	Have you been kept waiting too long by pharmacists, by our Member Services, or by other staff at the plan? Examples include waiting too long on the phone or when getting a prescription.
Cleanliness	Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	Do you believe we have not given you a notice that we are required to give? Do you think written information we gave you is hard to understand?
Timeliness These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals.	The process of asking for a coverage decision and filing appeals is explained in Sections 4, 5, and 6 of this chapter. If you are asking for a decision or filing an appeal, use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can file a complaint about our slowness. Here are examples: • If you have asked us to give you a fast coverage decision or a fast appeal, and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have filed, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

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

Section 7.3 Step-by-step: Making a complaint

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

- **Usually, calling Optum Rx is the first step**. If there is anything else you need to do, we will let you know. Our contact information is on the front cover of this document.
- If you do not want to call, or you called and were not satisfied, you can put your complaint in writing and send it to us. If you do this, it means that we will use our formal procedure for answering grievances. Here is how it works:

  Send your complaint in writing to us at:

  Optum Rx
  Attn: Part D Grievances
  6868 W 115th St
  Overland Park, KS 66211

- Whether you call or write, you should contact Optum Rx right away. The complaint must be made within 60 days after you had the problem you want to complain about.
- If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you an answer within 24 hours.

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

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered within 30 days**, but we may take up to 44 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 days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or do not take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

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

When your complaint is about **quality of care**, you also have 2 extra options:

- You can **make your complaint to the Quality Improvement Organization directly (without making the complaint to us)**. The Quality Improvement Organization is a group of practicing doctors and other healthcare experts paid by the federal government to check and improve the care given to Medicare patients.
- Or you can **make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2 of this document. If you make a complaint to this organization, we will work with them to resolve your complaint.

Section 7.5 You can also tell Medicare about your complaint.

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to medicare.gov/medicarecomplaintform.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048.

Chapter 8. Ending your coverage in the plan

SECTION 1 Introduction

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

Ending your membership in the County of Orange Medicare Prescription Drug 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.
- There are also limited situations where you do not choose to leave but we are required to end your membership. Section 5 of this chapter explains situations when we must end your coverage.

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

SECTION 2 When you can end your membership in our plan

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

Members of the County of Orange Medicare Prescription Drug Plan fall into a Special Enrollment Period because you are part of an Employer Group Waiver Plan, which means you are allowed to end your membership any time throughout the year.

You can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:

- Another Medicare Prescription Drug Plan
- Original Medicare without a separate Medicare Prescription Drug Plan
- A Medicare Advantage Plan – A Medicare Advantage Plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage Plans also include Part D prescription drug coverage.

If you enroll in most Medicare Advantage Plans, you will automatically be disenrolled from this plan when your new plan's coverage begins. However, if you choose a Private Fee-for-Service Plan without Part D drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, you can enroll in that plan and keep our plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare Prescription Drug Plan or drop Medicare prescription drug coverage.

Note: If you disenroll from a Medicare Prescription Drug Plan and go without creditable prescription drug coverage for 63 or more days in a row, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. "Creditable drug coverage" is drug coverage that meets Medicare's minimum standards.

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

Note: Before disenrolling from our plan, you should first contact the plan you wish to enroll in and confirm that they will accept your application. If they enroll you, you will automatically be disenrolled from our plan.

Section 2.2 Where to find more information about when you can end your enrollment

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

- **Call Optum Rx** – Our contact information is on the front cover of this document.
- Find the information in the ***Medicare & You*** handbook
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - Download a copy from medicare.gov or order a printed copy by calling Medicare at the number below.
- **Contact Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week

SECTION 3 How to end your membership in our plan

Section 3.1 You end your membership by enrolling in another plan

To end your membership in our plan, simply enroll in another Medicare plan. However, there are a couple of exceptions.

One exception is when you want to switch from our plan to Original Medicare *without* a Medicare Prescription Drug Plan. In this situation, you must contact the County of Orange and ask to be disenrolled from our plan.

Another exception is if you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan. In this case, you can enroll in that plan and keep the County of Orange Medicare Prescription Drug Plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare Prescription Drug Plan or to drop your Medicare prescription drug coverage.

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

If you would like to switch from our plan to:	This is what you should do:
Another Medicare Prescription Drug Plan	Enroll in the new Medicare Prescription Drug Plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
A Medicare health plan	Enroll in the Medicare health plan. With most Medicare health plans, you will automatically be disenrolled from our plan when your new plan's coverage begins. If you choose a Private Fee-for-Service Plan without Part D drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, you can enroll in that new plan and keep our plan for your drug coverage. If you want to leave our plan, you must either enroll in another Medicare Prescription Drug Plan or ask to be disenrolled. To ask to be disenrolled, you must send us a written request. **Contact Optum Rx** if you need more information on how to do this. Our contact information is on the front cover of this document. You can also **contact Medicare** at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week.
Original Medicare without a separate Medicare Prescription Drug Plan. **Note:** If you disenroll from a Medicare Prescription Drug Plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 4 of this document for more information about the late enrollment penalty.	**Send us a written request to disenroll.** Contact Optum Rx if you need more information on how to do this. Our contact information is on the front cover of this document. You can also **contact Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048, 24 hours a day, 7 days a week and ask to be disenrolled.

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

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

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

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

SECTION 5 The County of Orange Medicare Prescription Drug Plan must end your coverage in certain situations

Section 5.1 When we must end your coverage

We must end your coverage with our plan if any of the following happen:

- You no longer have Medicare Part A and/or Part B. **You must have either Part A or Part B.)**
- You move out of the United States, District of Columbia, Puerto Rico, Guam, the US Virgin Islands, Northern Mariana Islands, or American Samoa for more than 12 months.
- You become incarcerated.
- You are no longer a United States citizen or lawfully present within the service area.
- You lie about, or withhold information about, other insurance you have that provides prescription drug coverage.
- You intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- 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.
- You let someone else use your member ID card to get prescription drugs.
  - If we end your coverage because of this reason, Medicare may have your case investigated by the Inspector General.
- You do not pay any applicable plan premiums as required by County of Orange.
  - We must notify you in writing to end your membership.
- You no longer meet the County of Orange eligibility requirements.

Note: 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 to get more information

You can **call Optum Rx** if you have questions or would like more information on when we can end your membership. Our contact information is on the front cover of this document.

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

What to do if this happens

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

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

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

Chapter 9. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, please call Optum Rx. Out contact information is located on the front cover of this document. If you have a complaint, such as a problem with wheelchair access, Optum Rx 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, County of Orange as a Medicare Prescription Drug Plan sponsor, we 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 Notices about fraud, waste, and abuse

Fraud, waste, and abuse is a serious matter. It is in your best interest to protect yourself from fraudulent schemes. CMS has partnered with a national Medicare Drug Integrity Contractor (MEDIC) to help detect, correct, and prevent fraudulent behavior within Medicare Part C and Medicare Part D. In collaboration with CMS, the MEDIC has developed several pamphlets that are designed to provide you with critical information related to fraud, waste, and abuse. They include information on what to look for and how to report it if you suspect that you may have been subjected to fraud. These pamphlets can be found online at **optumrx.com** on the "Forms" page.

You can call MEDIC customer service toll-free at 1-877-7SAFERX (1-877-772-3379)

Chapter 10. Definitions of important words

Appeal – An appeal is something you file if you disagree with our decision to deny a request for healthcare services or prescription drugs, or payment for services or drugs you already received. You may also file an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if our plan does not pay for a drug, item, or service you think you should be able to receive. Chapter 7 of this document explains appeals, including the process involved in filing an appeal.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug; however, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,400 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs Medicare.

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

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

Cost Sharing – The amount you have to pay when drugs are received. It 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; and (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 Drug List is in a cost-sharing tier. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about (1) whether or not a drug prescribed for you is covered by the plan and (2) the amount, if any, you are required to pay for the prescription. In general, if you take your prescription to a pharmacy and the pharmacy tells you the prescription is not covered by your plan, this is not considered a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, 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.

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

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

Drug List (Formulary) – A list of covered Part D drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Employer Group Waiver Plan (EGWP) – Medicare Part D plan that is sponsored by a former employer, union, or trustees of a fund.

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (also called a formulary exception), or allows you to get a non-preferred drug at the preferred cost-sharing level (also called a tier exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting or if the plan limits the quantity or dosage of the drug you are requesting (also called a utilization management exception).

Extra Help/Low-Income Subsidy – 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 a brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you will pay the standard premium amount (if applicable) plus an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra amount 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 – The stage in your benefits where you pay a copayment or coinsurance for your drugs until your Part D out-of-pocket costs have reached the $7,400 limit for the calendar year.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

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

Medicare – The federal health insurance program for people 65 or older, some people under 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 (Medicare Part C) – A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (hospital) and Part B (medical) benefits. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with end-stage renal disease (unless certain exceptions apply).

Medicare 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 – An individual 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).

Member Services – The department within our plan that is responsible for answering your questions about your enrollment, benefits, grievances, and appeals.

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

Original Medicare (“Traditional Medicare” or “Fee-for-Service” Medicare) – Original Medicare is offered by the government and is 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 healthcare providers' payment amounts established by Congress. You can see any doctor, hospital, or other healthcare 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. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

Part C – See “Medicare Advantage (MA) Plan.”

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

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. See your Drug List or “Formulary” for a specific list of covered drugs. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Premium – The periodic payment to Medicare, an insurance company, or a healthcare 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. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the Drug List.

Quality Improvement Organization (QIO) – Group of practicing doctors and other healthcare experts paid by the federal government to check and improve the healthcare given to Medicare patients. They must review your complaints about the quality of care given by Medicare providers. See Chapter 2 of this document for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO.

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

Service Area – The geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan and, in the case of network plans, where a network must be available to provide services.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare.

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

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

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If you believe we have failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can send a complaint to:

Optum Rx Civil Rights Coordinator
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Eden Prairie, MN 55344

Phone: **1-800-562-6223 (TTY 711)**
Fax: 1-855-351-5495
Email: **Optum_Civil_Rights@Optum.com**

If you need help filing a complaint, please call the number located on the back of your prescription ID card (TTY 711). Representatives are available 24 hours a day, 7 days a week. You can also file a complaint directly with the U.S. Department of Health and Human Services online, by phone, or by mail:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at:
https://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free **1-800-368-1019**, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

This information is available in other formats like large print. To ask for another format, please call the telephone number listed on your health plan ID card.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-908-9097. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-908-9097. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-908-9097。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-908-9097。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-908-9097. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-908-9097. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-908-9097 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-908-9097. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-908-9097 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-908-9097. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-908-9097** سيقوم شخص ما يتحدث العربية . بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-908-9097 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-908-9097. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-908-9097. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-908-9097. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-908-9097. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-908-9097 にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。