Evidence of Coverage 2026

State Health Plan PPO Medicare Prescription Drug (PDP) Coverage

Administered by Optum Rx®

Effective January 1, 2026 – December 31, 2026

Optum Rx Member Services

For questions about this document, please contact M- ember Services. This call is free.

optumrx.com/som

Toll-free **1-866-635-5941,** TTY **711**
24 hours a day, 7 days a week

This document provides details about your Medicare drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place**.

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

- Our plan premium and cost sharing
- Our drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

This plan is offered by the State Health Plan PPO, referred to throughout the *Evidence of Coverage* as "we," "us," or "our." The State Health Plan PPO 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, 2027.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

Optum Rx®

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CHAPTER 1:
Get started as a member

SECTION 1 You're a member of the State Health Plan PPO Medicare Prescription Drug Plan

Section 1.1 You're enrolled in the State Health Plan PPO Medicare Prescription Drug Plan, which is a Medicare Prescription Drug Plan

You're covered by Original Medicare or another health plan for your health care coverage, and you chose to get your Medicare drug coverage through our plan, the State Health Plan PPO.

The State Health Plan PPO Medicare Prescription Drug Plan is a Medicare drug plan (PDP). Like all Medicare plans, this Medicare drug plan is approved by Medicare and run by a private company.

Section 1.2 Legal Information

This *Evidence of Coverage* is part of our contract with you about how the State Health Plan PPO 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 the State Health Plan PPO between January 1, 2026, and December 31, 2026.

Each calendar year, Medicare allows us to make changes to the plans we offer. This means we can change the costs and benefits for our plan after December 31, 2026. We can also choose to stop offering the plan or offer it in a different service area after December 31, 2026.

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

SECTION 2 Plan Eligibility Requirements

Section 2.1 Eligibility Requirements

You are eligible for membership in our plan as long as you meet all these conditions:

- Live in our geographic service area. (described in Section 2.2) People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You have Medicare Part A and Medicare 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 Plan Service area for the State Health Plan PPO Medicare Prescription Drug Plan

The State Health Plan PPO Medicare Prescription Drug Plan is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. Our service area includes all 50 US 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, call Optum Rx at **1-866-635-5941**, TTY **711** to see if we have a plan in your new area. 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.

If you move or change your mailing address, it is also important that you call the Social Security Administration at **1-800-772-1213** TTY **1-800-325-0778**.

Section 2.3 U.S. Citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify the State Health Plan PPO Medicare Prescription Drug Plan if you're not eligible to stay a member of our plan. The State Health Plan PPO Medicare Prescription Drug Plan, must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample membership card:

Carry your card with you at all times and remember to show your card each time you get covered drugs. If our plan membership card is damaged, lost, or stolen, call Optum Rx at **1-866-635-5941**, TTY **711** right away and we'll 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 or Medicaid card to get covered medical care and services under Original Medicare.

Section 3.2 Pharmacy Directory

The Pharmacy Directory (found under Member Tools > Pharmacy Locator) lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the Pharmacy Directory to find the network pharmacy you want to use. Go to Chapter 3, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

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 Member Tools > Pharmacy Locator). You can also call Optum Rx **1-866-635-5941**,TTY **711** for help or have us mail you a copy.

Section 3.3 Drug List (formulary)

Our plan has a List of Covered Drugs (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in State Health Plan PPO Medicare Prescription Drug Plan. The drugs on this list are selected with the help of a team of doctors and pharmacists and must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 3, Section 6. Medicare has approved the State Health Plan PPO Medicare Prescription Drug Plan Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

If you need a copy of the Drug List, there are 3 ways to get the most complete and current information about which drugs are covered drugs:

- Visit **optumrx.com** > Member tools > Drug pricing and information.
- Visit **optumrx.com**> Information Center > Programs & Forms to download a copy.
- Call Optum Rx at **1-866-635-5941**, TTY **711** to have us mail you a copy.

SECTION 4 Your monthly costs for the State Health Plan PPO Medicare Prescription Drug Plan

	Your Costs in 2026
Monthly plan premium* * Your premium can be higher	Please contact the Office of Retirement Services (ORS) at **800-381-5111**, Monday – Friday, 8:30 a.m. – 5:00 p.m. Eastern time with questions regarding any plan premium you may have.
Part D drug coverage deductible (Go to Chapter 4 Section 4 *[edit section number as needed]* for details.)	**This plan does NOT have a Deductible. This stage does not apply to you.**
Part D drug coverage initial coverage (Go to Chapter 4 Section 4 *[edit section number as needed]* for details.)	During this stage, the plan pays its share of the cost and you pay your share of the cost of your drugs. You stay in this stage until your year-to-date Part D out-of-pocket costs (your payments) reach a total of $2,100. 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 $2,000. Once you reach your enhanced plan out-of-pocket maximum of $2,000, the plan will pay **all** of your drug costs for the remainder of the year.
Part D drug coverage catastrophic coverage (Go to Chapter 4 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	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 $2,100. 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 $2,000. Once you reach your enhanced plan out-of-pocket maximum of $2,000, the plan will pay **all** of your drug costs for the remainder of the year.

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan Premium

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).

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the benefits administrator for your employer, union, or fund for more information about our plan 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. These include Extra Help and State Pharmaceutical Assistance Programs. Learn more about these programs in Chapter 2, Section 7. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are already get help from one of these programs, some of the payment information in this *Evidence of Coverage* may not apply to you. We sent you a separate notice, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rid*er or the *LIS Rider*), which tells you about 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 at **1-866-635-5941**, TTY **711** and ask for your “Low Income Subsidy Rider.”

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of Medicare & You 2026 handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website (**medicare.gov/medicare-and-you**) or you can order a printed copy by phone at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums.

In addition to paying the monthly plan premium, you must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren’t eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in the State Health Plan PPO Medicare Prescription Drug Plan, we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.
    - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.
    - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2025 this average premium amount was $36.78. This amount may change for 2026.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14% times $36.78, which equals $5.15. This rounds to $5.10. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amont (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit Medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

If you are participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe

for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

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

SECTION 5 Keep our plan membership record up to date

Your membership record has information from your electronic election of our plan, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your 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 or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling the ORS at **1-800-381-5111**, Monday – Friday, 8:30 a.m. – 5:00 p.m. Eastern time, for more information.

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at **1-800-772-1213** (TTY users call **1-800-325-0778**).

SECTION 6 How other insurance works with our plan

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. **If it is correct, you don't need to do anything**. If the information is incorrect, or if you have other coverage that is not listed, please call Optum Rx at **1-866-635-5941**, TTY **711**. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that

pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary payer. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

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

- If you have retiree coverage, Medicare pays first. (There may be some exceptions).
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD).
    - If you 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 or domestic partner 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. TRICARE payments do not count toward your out-of-pocket costs.

CHAPTER 2:
Phone numbers and resources

SECTION 1 Contacts

For help with claims, billing, or ID card questions, call Optum Rx at **1-866-635-5941**, TTY **711**. We are available to assist you 24 hours a day, 7 days a week.

Optum Rx Member Services – Contact Information	
CALL	**1-866-635-5941** Calls to this number are free. *24 hours a day, 7 days a week.* Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 24 hours a day, 7 days a week.
WRITE	Optum Rx PO Box 2975 Mission, KS 66201-1375
WEBSITE	**optumrx.com**

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

A coverage decision is a decision we make about your coverage or about the amount we will pay for your Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on asking for coverage decisions or appeals about your Part D drugs, see Chapter 7

Coverage Decisions and Appeals for Medical Care or Part D drugs – Contact Information	
CALL	**1-866-635-5941** Calls to this number are free. *24 hours a day, 7 days a week.* Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 24 hours a day, 7 days a week.
Fax	1-877-239-4565
WRITE	Optum Rx Attn: Prior Authorization Department PO Box 2975 Mission, KS 66201-1375
WEBSITE	**optumrx.com**

How to make a complaint

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint, go to Chapter 7.

Comments, Complaints & Grievances – Contact Information	
CALL	**1-866-635-5941** Calls to this number are free. *24 hours a day, 7 days a week.* Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 24 hours a day, 7 days a week.
Fax	1-866-235-3171
WRITE	Optum Rx Attn: Part D Grievances 6868 W 115th Street Overland Park, KS 66211
WEBSITE	**optumrx.com**
Medicare website	To submit a complaint about the State Health Plan PPO Medicare Prescription Drug Plan directly to Medicare, go to **Medicare.gov/MedicareComplaintForm/home.aspx**.

How to ask us to pay our share of the cost of a drug you got

If you got a bill or paid for drugs (like a pharmacy bill) you think we should pay for, you may need to ask our plan for reimbursement or to pay the pharmacy bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Manual Claims Submission, Payment Requests, & Claim Appeals – Contact Information	
CALL	**1-866-635-5941** Calls to this number are free. *24 hours a day, 7 days a week.* Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 24 hours a day, 7 days a week.
WRITE	Optum Rx Attn: Manual Claims PO Box 2975 Mission, KS 66201-1375
WEBSITE	**optumrx.com**

SECTION 2 Get Help from Medicare

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** Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. Find Medicare-participating doctors or other health care providers and suppliers. Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). Get Medicare appeals information and forms. Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about the State Health Plan PPO Medicare Prescription Drug Plan. **To submit a complaint to Medicare**, go to **Medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

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 (SHIP)	1-800-224-6330
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	Georgia 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
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

State Health Insurance Assistance Programs (SHIPs)		
State	**Agency Name**	**Phone Number**
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	Missouri SHIP	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	Pennsylvania Medicare Education and Decision Insight, PA MEDI	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
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	Virginia Insurance Counseling and Assistance Program (VICAP)	1-800-552-3402
VI	Virgin Islands State Health Insurance Assistance Program (VISHIP)	1-340-772-7368

State Health Insurance Assistance Programs (SHIPs)		
State	**Agency Name**	**Phone Number**
VT	Vermont State Health Insurance Assistance Program	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 Insurance 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 Organizations (QIO)

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	Acentra Health	1-888-305-6759
AL	Acentra Health	1-888-317-0751
AM	Livanta	1-684-699-3330
AR	Acentra Health	1-888-315-0636
AZ	Livanta	1-877-588-1123
CA	Livanta	1-877-588-1123
CO	Acentra Health	1-888-317-0891
CT	Acentra Health	1-888-319-8452
DC	Livanta	1-888-396-4646
DE	Livanta	1-888-396-4646
FL	Acentra Health	1-888-317-0751

Quality Improvement Organizations (QIO)		
State	**Agency Name**	**Phone Number**
GA	Acentra Health	1-888-317-0751
GU	Livanta	1-671-685-2689
HI	Acentra Health	1-877-588-1123
IA	Livanta	1-888-755-5580
ID	Acentra Health	1-888-305-6759
IL	Livanta	1-888-524-9900
IN	Livanta	1-888-524-9900
KS	Livanta	1-888-755-5580
KY	Acentra Health	1-888-317-0751
LA	Acentra Health	1-888-315-0636
MA	Acentra Health	1-888-319-8452
MD	Livanta	1-888-396-4646
ME	Acentra Health	1-888-319-8452
MI	Livanta	1-888-524-9900
MN	Livanta	1-888-524-9900
MO	Livanta	1-888-755-5580
MS	Acentra Health	1-888-317-0751
MT	Acentra Health	1-888-317-0891
NC	Acentra Health	1-888-317-0751
ND	Acentra Health	1-888-317-0891
NE	Livanta	1-888-755-5580
NH	Acentra Health	1-888-319-8452
NJ	Livanta	1-866-815-5540
NM	Acentra Health	1-888-315-0636
NMI	Livanta	1-670-989-2686
NV	Livanta	1-877-588-1123
NY	Livanta	1-866-815-5440
OH	Livanta	1-888-524-9900
OK	Acentra Health	1-888-315-0636

Quality Improvement Organizations (QIO)		
State	**Agency Name**	**Phone Number**
OR	Acentra Health	1-888-305-6759
PA	Livanta	1-888-396-4646
PR	Livanta	1-787-520-5743
RI	Acentra Health	1-888-319-8452
SC	Acentra Health	1-888-317-0751
SD	Acentra Health	1-888-317-0891
TN	Acentra Health	1-888-317-0751
TX	Acentra Health	1-888-315-0636
UT	Acentra Health	1-888-317-0891
VA	Livanta	1-888-396-464
VI	Livanta	1-888-396-4646
VT	Acentra Health	1-888-319-8452
WA	Acentra Health	1-888-305-6759
WI	Livanta	1-888-524-9900
WV	Livanta	1-888-396-4646
WY	Acentra Health	1-888-317-0891
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 determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

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

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. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and Medicare Savings Programs, contact your state's Medicaid Agency. Here is a list of Medicaid Agencies by state:

State Medicaid Offices		
State	**Agency Name**	**Phone Number**
AL	Alabama Medicaid	1-334-242-5000
AK	Alaska Medicaid	1-800-780-9972
AS	American Samoa	1-684-699-4777
AR	Arkansas Medicaid	1-501-682- 8233 or 1-800-482-8988
AZ	Arizona Health Care Cost Containment System (AHCCCS)	1-602-417-4000 or 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	1-855-805-4325 1-855-626-6632
DC	DC Medicaid	1-855-532-5465
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	(Central Office - Mangilao) 1-671-300-8853, 1-671-300-8854, 1-671-300-8855, or 1-671-300-8856 (Northern Office - Dededo) 1-671-635-7429, 1-671-635-7439, 1-671-635-7484, 1-671-635-7488, or 1-671-635-7396 (Southern Office - Inarajan) 1-671-828-7542, 1-671-828-7524, or 1-671-828-7534
HI	Hawaii Med-QUEST Division	1-808-524-3370 or 1-800-316-8005
IA	Iowa Health and 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	1-800-403-0864
KS	KanCare	1-800-792-4884
KY	Kentucky Cabinet for Health and Family Services	1-855-306-8959

State Medicaid Offices		
State	**Agency Name**	**Phone Number**
LA	Healthy Louisiana	1-888-342-6207
MA	MassHealth	1-800-841-2900
MD	Maryland Department of Health	1-855-642-8572
ME	Maine Department of Health and Human Services	1-855-797-4357
MI	Michigan Department of Health and Human Services	1-833-599-6444
MN	Minnesota Department of Human Services	1-800-657-3672
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	1-800-755-2604
NE	Nebraska Department of Health and Human Services	1-855-632-7633
NH	New Hampshire Department of Health and Human Services	1-844-275-3447 select option #3
NJ	New Jersey Department of Human Services	1-800-701-0710
NM	New Mexico Human Services Department	1-800-283-4465
NV	Nevada Department of Health and Human Services	1-877-638-3472
NY	New York State Department of Health	1-855-355-5777
OH	Ohio Department of Medicaid	1-800-324-8680
OK	Oklahoma Health Care Authority	1-800-987-7767
OR	OregONEligibility*	1-800-699-9075
PA	Pennsylvania Department of Human Services	1-800-692-7462
PR	Medicaid Program Department of Health	1-787-641-4224
RI	Rhode Island Executive Office of Health and Human Services	1-855-840-4774
SC	South Carolina Health Connections Medicaid	1-888-549-0820
SD	South Dakota Department of Social Services	1-800-597-1603

State Medicaid Offices		
State	**Agency Name**	**Phone Number**
TN	Tennessee Department of Health	1-855-259-0701
TX	Texas Health and Human Services	1-800-335-8957
UT	Utah Department of Health Medicaid	1-866-435-7414
VA	Virginia Department of Medical Assistance Services	1-833-522-5582 (1-833-5CALLVA)
VI	Virgin Islands DHS	1-340-715-6929
VT	Vermont Health Connect	1-855-899-9600
WA	Washington State Health Care Authority	1-800-562-3022
WI	Wisconsin Department of Health Services	1-800-362-3002
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 Programs to help people pay for prescription drugs

The Medicare.gov website (https://medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly premium, yearly deductible, and copayments and coinsurance. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a purple letter to let you know. You will not have to apply. If you do not automatically qualify you can apply anytime. To if you quality for getting Extra help:

- Visit **secure.ssa.gov/i1020/start** to apply online.
- Call Social Security at **1-800-772-1213**, between 8 am to 7 pm, Monday through Friday. TTY users should call **1-800-325-0778**.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right

copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- Your State Medicaid Office (See Section 6 of this chapter for contact information).
- Please call the member services number in Chapter 2 Section 1. Our Member Services Advocates can help get your copayment amount corrected.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at **1-866-635-5941**, TTY **711** if you have questions.

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

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

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

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

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing help.

Note: To be eligible for the ADAP in your State, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call your state ADAP office listed below.

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

State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
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	1-855-805-4325	n/a
DC	Department of Health - District of Columbia	n/a	1-202-639-4030	n/a
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

State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
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
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
NMI	Department of Human Services of Hawaii	1-800-316-8005	1-808-524-3370	1-800-316-8005

State Medical Assistance Offices				
State	**Agency Name**	**Toll Free Number**	**Local Number**	**Español Teléfono**
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
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.

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

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/HIV 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 – also Ryan White Part B	1-303-692-2687
CO	Colorado Bridging the Gap	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 Health and Human Services Benefits and Drug Assistance Program	1-515-204-3746
ID	IDAGAP	1-208-334-6526
IL	Illinois AIDS Drug Assistance Program (ADAP)	1-217-524-5983
IN	HIV Services Program	1-317-234-1811
IN	HoosierRx	1-866-267-4679
KS	Kansas ADAP	1-785-213-9546
KY	Kentucky ADAP	1-502-564-6356
LA	Louisiana Health Access Program	1-504-931-2642
LA	SHHP	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	1-800-551-5995

State Pharmaceutical Assistance Programs (SPAPs)		
State	**Agency Name**	**Phone Number(s)**
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	1-984-236-4128
ND	North Dakota AIDS Drug Assistance Program (ADAP)	1-701-328-2379
NH	New Hampshire AIDS Drug Assistance Program (ADAP)	1-603-271-4502
NJ	NJ AIDS Drug Distribution program (NJADDP)	1-877-613-4533
NJ	NJPAAD Program	1-800-792-9745
NJ	NJ Senior Gold Discount card program	1-603-271-4502
NM	NMMIP SPAP	1-620-793-1121
NM	New Mexico Medical Insurance Pool	1-844-728-7896
NV	Nevada Medication Assistance Program (NMAP)	1-888-475-3219
NY	NYS EPIC	1-800-332-3742
NY	NYS Uninsured Care Programs	1-518-459-1641
OH	Ohio ADAP	1-614-728-2167
OR	CAREAssist	1-971-673-0142
PA	PACE	1-717-787-7313
PA	PACENET	1-717-787-7313
PA	Special Pharmaceutical Benefits Program/ADAP	1-800-225-7223
PA	Special Pharmaceutical Benefits Program - Mental Health	1-877-356-5355
PA	Chronic Renal Disease Program (CRDP)	1-800-225-7223

State Pharmaceutical Assistance Programs (SPAPs)		
State	**Agency Name**	**Phone Number(s)**
PR	Puerto Rico Ryan White Part B/ADAP	1-787-765-2929
RI	Rhode Island State Pharmaceutical Assistance to the Elderly	1-401-462-0560
SC	South Carolina AIDS Drug Assistance Program (HIV+)	1-800-856-9954
SD	South Dakota Department of Health Ryan White Part B	1-605-773-3737
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	1-801-518-1303
VA	Virginia State Pharmaceutical Assistance Program	1-855-362-0658
VT	ADAP	1-802-863-7244
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	1-307-777-6583
Contact information is subject to change throughout the year. For the most up-to-date contact information, visit medicare.gov.		

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Optum Rx at **1-844-368-8729**, TTY **711** or visit **Medicare.gov**.

Method	The Medicare Prescription Payment Plan – Contact Information
CALL	**1-844-368-8729** Calls to this number are free. 24 hours a day, 7 days a week including information on the use of alternative technologies. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711**
WRITE	Optum Rx Attn: Member Services 6868 W 115th St Overland Park, KS 66211
WEBSITE	**optumrx.com**

SECTION 8 Railroad Retirement Board (RRB)

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 get your Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – 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 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at **1-866-635-5941**, TTY **711** with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits,

premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call **1-800-MEDICARE** (**1-800-633-4227**) with questions about your Medicare coverage under this plan. TTY users call **1-877-486-2048**.

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

Important Note: Your (or your spouse or domestic partner's) employer/union benefits may change, or you or your spouse or domestic partner may lose the benefits, if you or your spouse or domestic partner 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 or domestic partner enroll in a Part D plan.

CHAPTER 3:
Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D drug coverage

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 2026 handbook at **medicare.gov/medicare-and-you***.) Your Part D prescription drugs are covered under our plan. Or you can order a printed copy by phone at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription or you can fill your prescription through our plan's mail-order service (Go to Section 2).
- Your drug must be on our plan's Drug List (Go to Section 3).
- 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 (FDA) or supported by certain references. (Go to Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)
- You must have a provider (doctor, dentist, or other prescriber) write your prescription.

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

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

Section 2.1 Network pharmacies

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 Member Tools > Pharmacy Locator tool).
- Call Optum Rx at **1-866-635-5941**, TTY **711**.

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.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another network pharmacy in your area, you can use your *Pharmacy Directory* (found under Member Tools > Pharmacy Locator), get help from Optum Rx at **1-866-635-5941**, TTY **711**, or visit **optumrx.com**.

Specialty pharmacies

Some 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 (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Optum Rx at **1-866-635-5941**, TTY **711**.
- 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 at **1-866-635-5941**, TTY **711**.

Section 2.2 Our plan's home delivery service

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. These drugs are marked as **mail-order drugs** in our Drug List. The drugs that aren't available through our plan's home delivery are marked with an asterisk in our Drug list.

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

To get order forms and information about filling your prescriptions by mail, call Optum Rx at **1-866-635-5941**, TTY **711** or visit our website at **optumrx.com**.

Usually, home delivery orders will be delivered to you in no more than 7 to 10 business days. Optum Rx will contact you if there will be an extended delay in delivering your medications.

New prescriptions the pharmacy gets 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, either:

- You used home delivery services with this plan in the past , or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of all new prescriptions at any time.

If you no longer want the pharmacy to automatically fill and ship a new prescription, call Optum Rx at **1-866-635-5941**, TTY **711** as soon as possible.

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

If you used mail order in the past and don't want the pharmacy to automatically fill and ship each new prescription, call Optum Rx at **1-866-635-5941**, TTY **711**.

If you have never used home delivery and/or decide to stop automatic fills of new prescriptions from a health-care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, call Optum Rx at **1-866-635-5941**, TTY **711**.

Refills on mail-order prescriptions. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

Contact your pharmacy before your current prescription runs out. This will ensure your order is shipped to you in time.

Section 2.3 How to get a long-term supply of drugs

Our plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs 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.

1. Your Pharmacy Directory (found under Member Tools > Pharmacy Locator) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Optum Rx at **1-866-635-5941**, TTY **711** for more information.

2. 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 2.2 for more information about using our home delivery services.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy when you aren't able to use a network pharmacy. **Check first with Optum Rx at 1-866-635-5941, TTY 711** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- 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.

If you must use an out-of-network pharmacy to fill a prescription, you'll generally have to pay the full cost (rather than paying your normal cost share) at the time you fill your prescription. Go to Chapter 5, section 2 for more information on how to ask the plan to pay you back. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List.**

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

Certain drugs may be covered for some medical conditions but are considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and on Medicare.gov, along with the specific medical conditions that they cover.

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

- A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.
- A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

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

Over-the-counter drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Optum Rx at **1-866-635-5941**, TTY **711**.

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 7.)

Section 3.2 Three cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of three cost-sharing tiers. In general, the higher the 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*.

* High-Cost (and some Specialty) drugs are those that cost $950 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.

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

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically. Visit our plan's website at **optumrx.com/som**. The Drug List on the website is always the most current.
- Call Optum Rx at **1-866-635-5941**, TTY **711** to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our "Real-Time Benefit Tool" to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. Visit **optumrx.com** and click on the Drug Information tool (found under Member Tools > Drug Information tool.)

SECTION 4 Drugs with restrictions on coverage

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

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

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 2 per day tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Optum Rx at **1-866-635-5941**, TTY **711** to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 7.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Optum Rx at **1-866-635-5941**, TTY **711** or on our website at **optumrx.com**.

Trying a different drug first

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

step therapy criteria can be obtained by calling Optum Rx at **1-866-635-5941**, TTY **711** or on our website at **optumrx.com**.

Quantity limits

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

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic of the drug may be covered but the brand-name version you want isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or if it is restricted, **here are options for what you can do**.

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

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

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

- **If you're a new member**, we'll cover a temporary supply of your drug during the first 90 days of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 30-day supply of medication. The prescription must be filled at a network pharmacy. (**Note**: a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need supplies right away**:

  We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply. For those members who are new to the plan and are in a long-term care facility:

For questions about a temporary supply, call Optum Rx at **1-866-635-5941**, TTY **711**.

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when the temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Optum Rx at **1-866-635-5941**, TTY **711** to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

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

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

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

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

You can change to another drug.

If your drug is in a cost-sharing tier you think is too high, talk with your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. You can call Optum Rx at **1-866-635-5941**, TTY **711** to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception.

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

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

SECTION 6 Our Drug List can change during the year

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

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

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during this plan year

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

restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We'll tell you at least 60 days before we make the change or tell you about the change and cover a 60-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
    - We may make other changes once the year has started that affect drugs you take. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - We'll tell you at least 60 days before we make these changes or tell you about the change and cover an additional 60-day fill of the drug you're taking.

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

Changes to the Drug List that don't affect you during this plan year

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

In general, changes that won't affect you during the current plan year are:

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

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other changes noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 7.)

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

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

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

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

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. The amount you pay for these drugs doesn't count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 6.)

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. Go to our plan's Drug List or call Optum Rx **1-866-635-5941**, TTY **711** for more information. If you have drug coverage through Medicaid, 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. Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.

SECTION 8 How to fill a prescription

To fill a prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will

automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't 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. Go to Chapter 5, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you are admitted to a hospital or to a skilled nursing facility, Original Medicare (or your Medicare health plan with Part A and B coverage, if applicable) will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

Section 9.2 As a resident in a long term care (LTC) facility

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

Check your *Pharmacy Directory* at **optumrx.com** to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Optum Rx at **1-866-635-5941**, TTY **711**. If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about a temporary or emergency supply.

Section 9.3 If you're taking drugs covered by Original Medicare

Your enrollment in the State Health Plan PPO Medicare Prescription Drug Plan doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you're enrolled in our plan. If your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through the State Health Plan PPO Medicare Prescription Drug Plan in other situations. Drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or our plan for the drug.

Section 9.4 If you have Medigap (Medicare Supplement Insurance) policy with coverage

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

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

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

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

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

Special note about creditable coverage

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

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

Keep these notices about creditable coverage, because you may need these notices later to show that you have maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't 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

We conduct drug-use reviews to help make sure our members get safe and appropriate care.

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

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

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

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

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

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

You won't be placed in our DMP if you have certain medical conditions such as cancer-related pain or sickle cell disease, if you're getting hospice, palliative, or end-of-life care, or you live in a long-term care facility.

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

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

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information, If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Optum Rx at **1-866-635-5941**, TTY **711**.

CHAPTER 4:
What you pay for Part D drugs

SECTION 1 What you pay for Part D Drugs

If you are in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may apply to you**. We have a separate insert, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage If you don't have this insert, call Member Services at **1-866-635-5941**, TTY **711** and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered by our plan if you purchased supplemental drug coverage.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. 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/som**.
- **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 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share. This plan does NOT have a Deductible.
- **Copayment** is a fixed amount you pay each time you fill a prescription.

- **Coinsurance** is a percentage of the total cost of the drug you pay each time you fill a prescription. This plan does NOT have a Coinsurance.

Section 1.2 How Medicare calculates your out-of-pocket costs

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

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

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

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan.
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

Most members do not reach the Catastrophic Coverage Stage because your enhanced benefits include a plan-specific out-of-pocket maximum of $2,000. Once you reach your out-of-pocket maximum of $2,000, the plan will pay all of your drug costs for the remainder of the year.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

-] Your monthly premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Prescription drugs covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan

- Payments you make toward drugs not normally covered in a Medicare Prescription Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder*:* If any other organization like the ones listed above pays part or all of your out-of-pocket costs for drugs, you're required to tell our plan by calling Optum Rx at **1-866-635-5941**, TTY **711**.

Tracking your out-of-pocket total costs

- The Part D Explanation of Benefits (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,100 the Part D EOB will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for State Health Plan PPO Medicare Prescription Drug Plan members

There are **3 drug payment stages** for your drug coverage under State Health Plan PPO. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Keep in mind you are always responsible for our plan's monthly premium regardless of the drug payment stage. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage. This plan does NOT have a Deductible. This stage does not apply to you.**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your Part D Explanation of Benefits (EOB) explains which payment stage you're in

Our plan keeps track of drug costs and the payments you make when you get your prescriptions at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pockets Costs:** this is how much you have paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions filled through our plan during the previous month, we'll send you a Part D EOB. The Part D EOB includes:

- **Information for that month** - This report gives payment details about prescriptions you filled during the previous month. It shows total drugs costs,, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1** - This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. displays. This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions**. This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

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 3.1 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's how you can help us keep your information correct and up to date:

- **Show your member card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug, in these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit
  - When you pay a copayment for drugs 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
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS Drug

Assistance Program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.

- **Check the written or electronic report we send you.** When you get a Part D EOC, in the mail or online, look it over to be sure the information is complete and correct. If you think something is missing from or you have questions, call Optum Rx at **1-866-635-5941**, TTY **711**. Be sure to keep these reports

SECTION 4 What you pay for Part D vaccines

Important –message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Refer to our plan's Drug List or call Optum Rx at **1-866-635-5941**, TTY **711** for coverage and cost sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

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

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

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

What you pay at the time you get an adult Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and for the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.

- Other times when you get the vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1 – You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2 –You get the vaccine at your doctor's office.

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost, by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any copayment for the vaccine (including administration) and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

Situation 3 –You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to 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.
- For most adult part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any copayment for the vaccine administration and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

CHAPTER 5:
Asking the plan to pay its share of the costs for covered drugs

SECTION 1 Situations when you should ask us to pay our share for covered drugs

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

Examples of situations in which you may need to ask our plan to pay you back or pay a bill you got:

1. **When you use an out-of-network pharmacy to fill a prescription**

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

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

2. **When you pay the full cost for a prescription because you do not have your plan membership card with you**

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

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

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

   You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on the plan's Drug List, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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 (If you have a problem or complaint (coverage decisions, appeals, complaints) has more information about how to file an appeal.

SECTION 2 How to ask us to pay you back

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

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website **optumrx.com** or call Optum Rx at **1-866-635-5941**, TTY **711** and ask for the form.

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

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

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

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

- If we decide the drug is covered and you followed all the rules we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the drug, we'll mail your reimbursement of our share of the cost to you. We'll send payment within 30 days after your request was received.
- If we decide the drug is **not** covered, or you did **not** follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal the decision.

Section 3.1 If we tell you that we won't pay for all or part of the drug, you can make an appeal

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

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 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, 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 and cultural sensitivities

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

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 languages other than English, 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 at **1-866-635-5941**, TTY **711**.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, call **1-866-635-5941**, TTY **711** to file a grievance. You can also file a complaint with Medicare by calling **1-800-MEDICARE** (**1-800-633-4227**) or directly with the Office for Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**.

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

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

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

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

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

How we protect the privacy of your health information

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we are required to get

written permission from you or someone you have given legal power to make decisions for you first.

- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
  - We're required to release health information to government agencies that are checking on quality of care.
  - Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires information that uniquely identifies you not be shared

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Optum Rx at **1-866-635-5941**, TTY **711**.

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

As a member of the State Health Plan PPO Medicare Prescription Drug 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 at **1-866-635-5941**, TTY **711**:

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

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to give instructions about what's to be done if you can 't 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.

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.

How to set up an advance directive to give instructions:

- **Get the form.** You can get a form from your lawyer, a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Optum Rx at **1-866-635-5941**, TTY **711** to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the State Department of Health.

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

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

Section 1.7 If you believe you're being treated unfairly, or your rights are not being respected

If you believe you've been treated unfairly or your rights haven't 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 you believe you've been treated unfairly or your rights haven't been respected, and it's not about discrimination, you can get help dealing with the problem you're having from these places:

- **Optum Rx Member Services at 1-866-635-5941, TTY 711**
- **Your local SHIP**
- **Medicare** at **1-800-MEDICARE** (**1-800-633-4227**), TTY **1-877-486-2048**

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Optum Rx at 1-866-635-5941, TTY 711.**
- **Call your local SHIP**
- **Contact Medicare.**
  - Visit medicare.gov to read the publication Medicare Rights & Protections (available at: 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 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Optum Rx at **1-866-635-5941**, TTY **711**. 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* to learn what's covered and the rules you need to follow to get covered drugs.
  - Chapters 3 and 4 provide details about Part D drug coverage.
- **If you have other drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordination of benefits.
- **Tell your doctor and pharmacist that you're enrolled in our plan**. Show our plan membership card whenever you get Part D drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
    - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have questions, be sure to ask and get an answer you can understand.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
    - For most of your drugs covered by our plan, you must pay your share of the cost when you get the drug.
    - If you are required to pay a late enrollment penalty, you must pay the penalty, you must pay the penalty to stay a member of our plan.
- If **you move within our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you. Please let us know by calling the ORS at 1-800-381-5111, Monday – Friday, 8:30 a.m. – 5:00 p.m. Eastern time.
- **If you move outside our plan service area, you can't stay a member of our plan. Please let us know by calling the ORS at 1-800-381-5111, Monday – Friday, 8:30 a.m. – 5:00 p.m. Eastern time.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns.

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

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

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Optum Rx at **1-866-635-5941**, TTY **711** for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

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

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

Medicare

You can also contact Medicare for help.

- 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 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 4**, **A guide to coverage decisions and appeals**.

No.

Go to **Section 7, How to make a complaint about quality of care, waiting times, member services, or other concerns**.

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your prescription drugs.

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide a drug isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed all of the rules. When we complete the review, we give you our decision.

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

If we don't dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal. (This chapter explains Level 3,4, and 5 appeals).

Section 4.1 Get help asking for a coverage decision or making an appeal

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

- **Call Optum Rx at 1-866-635-5941, TTY 711**.
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf**. You can name another person to act for you as your representative to ask for a coverage decision or to file an appeal.
    - If you want a friend, relative, or another person to be your representative, call Optum Rx at **1-866-635-5941**, TTY **711** and ask for the Appointment of Representative form. The form is also available on Medicare's website at: cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer**. You can 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 aren't required to hire a lawyer** to ask for any kind of coverage decision or to appeal a decision**.**

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

Section 5.1 What to do if you have problems getting a Part D drug or want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 3 and 4. **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating covered outpatient prescription drug or Part D drug every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

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

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

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

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

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

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

Section 5.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here 3 examples of exceptions that you or your doctor or other prescriber can ask us to make.

1. **Covering a Part D drug that's not on our Drug List.** If we agree cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to all drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our Drug List. For more information, go to Chapter 3 of this document.
3. **Changing coverage of a drug to a lower cost-sharing tier** - Every drug on our Drug List is in one of 3 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.

    - If your Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.

    - If the drug you're taking is a brand-name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand-name alternatives for treating your condition.

    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

    - .If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Our Drug List typically 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're asking for and wouldn't cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we generally won't approve your request for an exception. unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

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

Section 5.4 How to ask for a coverage decision, including an exception

Legal Terms:

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

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

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

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a drug you didn't get. (You can't ask a fast decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or other prescriber's support, we will decide whether your health requires that we give you a fast coverage decision**. If we don't approve a fast coverage decision, we will send you a letter that:
    - Explains that we'll use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.

- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

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

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

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

Deadlines for a fast coverage decision

- We must generally give you our answer within **24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no. We'll also tell you how you can appeal

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request
  - For exceptions, we'll give you our answer within 72 hours after we receive your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to provide **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you've already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 5.5 How to file a Level 1 Appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination**.

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

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

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

- If you're appealing a decision we made about a drug, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.4 of this chapter.

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

- **For standard appeals, submit a written request.** Chapter 2 has contact information or call Optum Rx at **1-866-635-5941**, TTY **711**.

- **For fast appeals, either submit your appeal in writing or Optum Rx at 1-866-635-5941**, TTY **711**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Redetermination Request Form, which is available on our website **optumrx.com**. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. we'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 72 hours, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we have agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how to appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within **30 calendar days** after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 5.6 How to make a Level 2 Appeal

Legal Term

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

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

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

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to file a Level 2 appeal** with the independent review organization. These instructions will tell who can file this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information we have about your appeal to the independent review organization. This information is called your case file. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying 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.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

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

For fast appeals:

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

For standard appeals:

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

What if the independent review organization says no to your appeal?

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

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

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

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

SECTION 6 Taking your appeal to Levels 3, 4 and 5

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

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

If the dollar value of the drug you appealed meets certain minimum levels, you may be able to go to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide not to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over**. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
    - If we decide not to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

Making complaints

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

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

The complaint process is only used for certain types of problems. This includes problems about quality of care, waiting times, and member services. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you got
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?

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

Section 7.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

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

A **fast complaint** is called an **expedited grievance**.

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

- **Calling Optum Rx at 1-866-635-5941, TTY 711 is usually the first step**. If there is anything else you need to do, we will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us**. If you put your complaint in writing, we'll respond to your complaint in writing.

  Send your complaint in writing to us at:

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

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

Section 7.3 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

or

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

Section 7.4 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/home.aspx**. You may also call **1-800-MEDICARE** (**1-800-633-4227**), TTY **1-877-486-2048**.

CHAPTER 8:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in the State Health Plan PPO Medicare Prescription Drug Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

SECTION 2 When can you end your membership in our plan

Members of the State Health Plan PPO 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 health plans, you'll 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 State Health Plan PPO Medicare Prescription Drug Plan for your drug coverage. If you don't 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 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call** the ORS at 1-800-381-5111, Monday – Friday, 8:30 a.m. – 5:00 p.m. Eastern time.
- Find the information in the ***Medicare & You 2026*** handbook
- Call **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

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from our plan when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from our plan when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• Call ORS at **1-800-381-5111**, Monday – Friday, 8:30 a.m. – 5:00 p.m. Eastern time. • You can also call **Medicare** at **1-800-MEDICARE** (**1-800-633-4227**) and ask to be disenrolled. TTY users call **1-877-486-2048**. • You'll be disenrolled from our plan when your coverage in Original Medicare starts.

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

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

- **Continue to use our network pharmacies or our home delivery service to get your prescriptions filled.**

SECTION 5 State Health Plan PPO Medicare Prescription Drug Plan must end our plan membership in certain situations

The State Health Plan PPO Medicare Prescription Drug Plan must end your membership in our plan if any of the following happen:

- If you no longer have either Medicare Part A or Part B (or both).
- If you move out of the service area or are away for more than 12 months.
  - If you move or take a long trip, call Optum Rx at **1-866-635-5941**, TTY **711** to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present within the service area.
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get prescription drugs. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- You do not pay our plan premiums for 2 or more calendar months.
  - We must notify you in writing that you have 2 months to pay our plan premium before we end your membership.
- You no longer meet the State Health Plan PPO Medicare Prescription Drug Plan eligibility requirements.

If you have questions or want more information on when we can end your membership, the ORS at **1-800-381-5111**, Monday – Friday, 8:30 a.m. – 5:00 p.m. Eastern time.

Section 5.1 We <u>can't</u> ask you to leave our plan for any health-related reason

The State Health Plan PPO Medicare Prescription Drug Plan isn't allowed to ask you to leave our plan for any health-related reason.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 9: Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, please call Optum Rx at **1-866-635-5941**, TTY **711**. 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, 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.

CHAPTER 10: Definitions

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

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

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

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

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

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

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

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Cost Sharing – Cost sharing refers to amounts a member has to pay when drugs are gotten. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed copayment amount that a plan requires when a specific drug is gotten; and (3) any coinsurance amount (a percentage of the total amount paid for a drug, that a plan requires when a specific drug is gotten.

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

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

Covered Drugs – The term we use to mean all 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.

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

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

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

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 your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the FDA as having the same active ingredient(s) as a brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

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

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

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

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

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

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.

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

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

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

Medicare – The federal health insurance program for people 65 years of age or older, some people under 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 Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage plan can be 1) an HMO, 2) a PPO, 3) a Private Fee-for-Service (PFFS) plan, or 4) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare 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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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

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

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

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

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

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

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other 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 doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of drugs gotten is also referred to as the member's out-of-pocket cost requirement.

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

Over-the-Counter (OTC) Drugs – A drug product that does not require a prescription under federal or state law.

Part C – See Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

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 based on specific criteria. Covered drugs that need prior authorization are marked in the Drug List.

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

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

Real Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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

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

Specialty Medication - Means drugs that have one or more of the following characteristics: (1) therapy of a chronic or complex disease; (2) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; (3) unique patient compliance and safety monitoring requirements; (4) unique requirements for handling, shipping, and storage; or (5) potential for significant waste due to the high cost of the drug.

Specialty Pharmacy- A licensed facility for the purpose of dispensing Specialty medication.

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

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

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

Tier 1 – Mostly 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*.

NOTICE OF NONDISCRIMINATION

OptumRx®, Inc. complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY **711**).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Optum Civil Rights Coordinator
1 Optum Circle
Eden Prairie, MN 55344
Optum_Civil_Rights@optum.com

If you need help filing a complaint, call the toll-free number **1-888-445-8745.** (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: ocrportal.hhs.gov/ocr/smartscreen/main.jsf

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

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

Complaint forms are available at hhs.gov/ocr/complaints/index.html.

This notice is available at optum.com/en/language-assistance-nondiscrimination.html.

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

Notice of Availability of Language Assistance Services and Alternate Formats

ATTENTION: Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card. TTY:**711**

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro. TTY: **711**

ملاحظة: إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាគតគិតថ្លៃ
និងការទំនាក់ទំនងឯកតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។
ទូរសព្ទមកលេខតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

请注意：如果您说**中文 (Chinese)**，我们可以为您提供免费语言协助服务以及大字印刷本等其他格式的免费通信。请致电您的会员身份卡上的免付费电话号码。

請注意：如果您說**中文 (Chinese)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

ATTENTION: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, muaj cov kev pab cuam txhais lus thiab muaj kev sib txuas lus pab dawb ua lwm hom ntawv, xws li luam ua ntawv loj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

ATENSION: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

ATTENZIONE: se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイアルにお電話ください。

알림 사항: 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

BAA'ÁKONÍNÍZIN: **Diné (Navajo)** saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó náánáł łahgo át'éego bee hadadilyaa bee ahxił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nitł'izí bee nééhoziní bąąh t'áá hiik'eh bee hane'í námboo bee hodíilnih.

توجه: اگر به زبان **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ВНИМАНИЕ! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

FIIRO GAAR AH: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Ka wac lambarka wicitaanka bilaashka ah kaarkaaga aqoonsiga xubinta.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

LƯU Ý: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.

Optum Rx Member Services

Method	Member Services – Contact Information
CALL	***1-866-635-5941*** **Calls to this number are free. *24 hours a day, 7 days a week.*** **Member Services also has free language interpreter services available non-English speakers.**
TTY	**711** Calls to this number are free. 24 hours a day, 7 days a week.
WRITE	**Optum Rx PO Box 2975 Mission, KS 66201-1375**
WEBSITE	**optumrx.com**