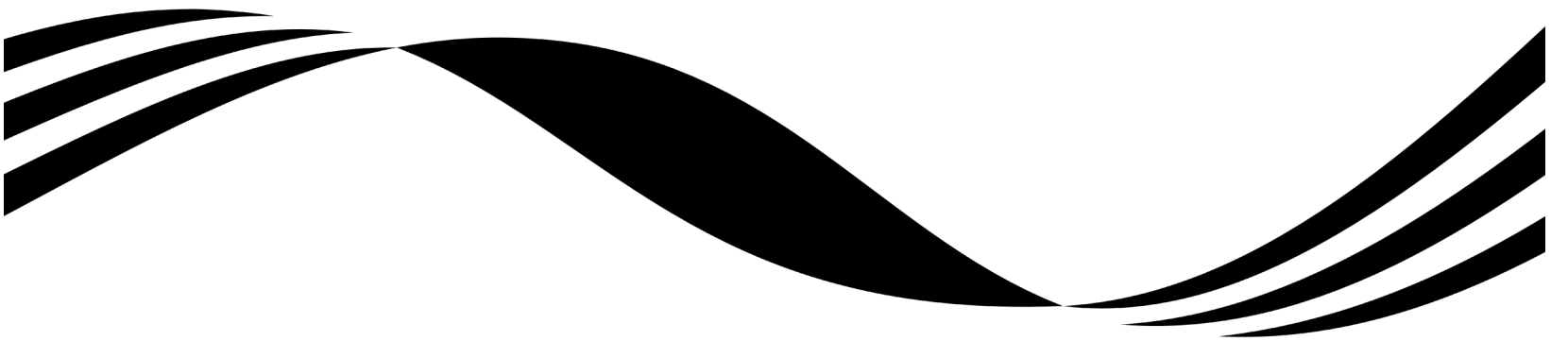
Evidence of Coverage 2027

UnitedHealthcare® MedicareRx for Groups (PDP)

Group Name (Plan Sponsor): CITY OF MILWAUKEE
Group Number: 24316



Download the **UnitedHealthcare app**

Visit **retiree.uhc.com**

Call toll-free **1-866-465-0572,** TTY **711**

8 a.m.-8 p.m. local time, Monday-Friday

United Healthcare®

Y0066_EOC_S5820_819_000_2027_C

January 1, 2027 - December 31, 2027

Evidence of Coverage for 2027

Your Medicare Drug Coverage as a Member of our plan

This document gives the details of your Medicare drug coverage from January 1, 2027 - December 31, 2027.

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

For questions about this document, call Customer Service at 1-866-465-0572 (TTY users call 711). Hours are 8 a.m.-8 p.m. local time, Monday-Friday. This call is free.

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

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

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

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.
Benefits and/or copayments/coinsurance may change on January 1, 2028.

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

OMB Approval 0938-1051 (Expires: July 31, 2029)

2027 Evidence of Coverage

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Chapter 1:

Get started as a member

Section 1 You're a member of UnitedHealthcare® MedicareRx for Groups (PDP)

Section 1.1 You're enrolled in UnitedHealthcare® MedicareRx for Groups (PDP), which is a Medicare 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, UnitedHealthcare® MedicareRx for Groups (PDP).

UnitedHealthcare® MedicareRx for Groups (PDP) 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 about the Evidence of Coverage

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

The contract is in effect for the months you're enrolled in the plan between January 1, 2027 and December 31, 2027.

Medicare allows us to make changes to plans we offer each plan year. This means we can change the costs and benefits of the plan after December 31, 2027. We can also choose to stop offering our plan, or to offer it in a different service area, after December 31, 2027.

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're eligible for membership in our plan as long as you meet all these conditions:

- You meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor)
- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B)
- You 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're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for UnitedHealthcare® MedicareRx for Groups (PDP)

Our 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. The service area is described below.

The service area for this Plan includes the 50 United States, the District of Columbia and the U.S. Territories.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at 1-866-465-0572 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

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

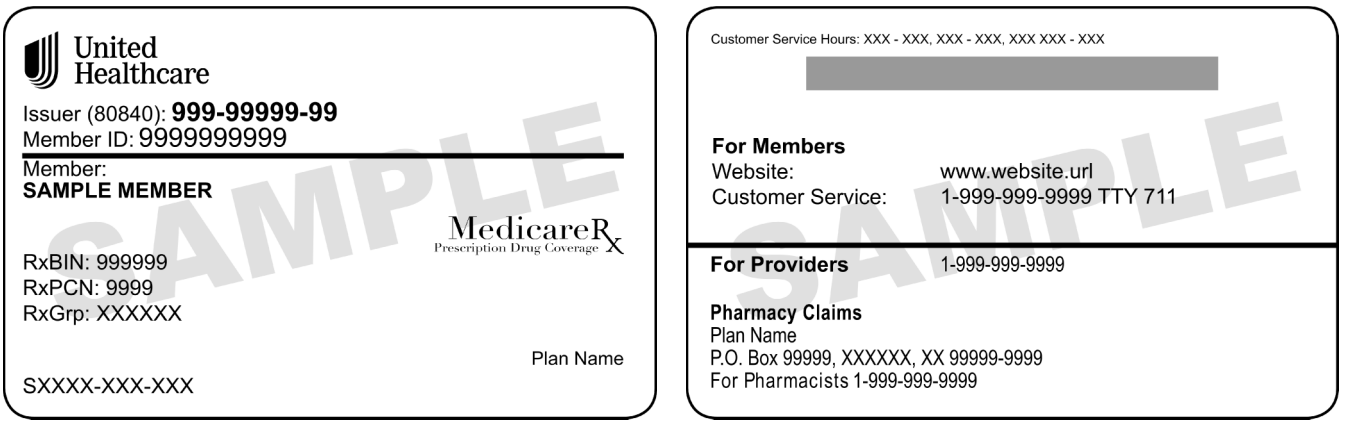
Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify UnitedHealthcare® MedicareRx for Groups (PDP) if you're not eligible to stay a member of our plan. UnitedHealthcare® MedicareRx for Groups (PDP) must disenroll you if you don't meet this requirement.

Section 3 Important membership materials

Section 3.1 Your UnitedHealthcare member ID card

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



Carry your card with you at all times and remember to show your card when you get covered drugs. If your plan member ID card is damaged, lost, or stolen, call Customer Service at 1-866-465-0572 (TTY users call 711) right away and we'll send you a new card.

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

Section 3.2 Pharmacy Directory

The Pharmacy Directory (retiree.uhc.com) 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 2.4 for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a **Pharmacy Directory**, you can ask for a copy from Customer Service at 1-866-465-0572 (TTY users call 711). You can also find this information on our website at retiree.uhc.com.

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 our plan. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 3, Section 6. Medicare approved the plan's Drug List.

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

The Drug List we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, visit retiree.uhc.com or call Customer Service at 1-866-465-0572 (TTY users call 711).

Section 4 Summary of Important Costs for 2027

	Your costs in 2027
Part D drug coverage deductible (Go to Chapter 4 Section 4 for details.)	Because we have no deductible, this payment stage does not apply to you.
Part D drug coverage (Go to Chapter 4 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage:** **Drug Tier 1:** Standard retail cost sharing (in-network) 20% coinsurance with a $75 maximum **Drug Tier 2:** Standard retail cost sharing (in-network) 20% coinsurance with a $75 maximum You pay $35 per month supply of each covered insulin product on this tier[1]. **Drug Tier 3:** Standard retail cost sharing (in-network) 20% coinsurance with a $75 maximum You pay $35 per month supply of each covered insulin product on this tier[1]. **Drug Tier 4:** Standard retail cost sharing (in-network)

	Your costs in 2027
	20% coinsurance with a $75 maximum You pay $35 per month supply of each covered insulin product on this tier[1]. **Catastrophic Coverage Stage:** • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for additional drugs that are covered under our enhanced benefit.

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

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 Adjustment Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium (if applicable)

Your coverage is provided through a contract with your current employer or former employer or union. As a UnitedHealthcare® MedicareRx for Groups (PDP) for Group retiree member, your plan sponsor may pay all or a portion of a monthly plan premium on your behalf. In some cases, however, your plan sponsor's administrators may have made arrangements with UnitedHealthcare to bill you, the member, directly for all or a portion of the plan premiums. If this is the case, please see "Section 5" below for more details. Contact the employer's or union's benefits administrator for information about our plan premium.

If you already get help from one of these programs, the **information about premiums in this Evidence of Coverage may not apply to you.** We sent you a separate insert, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, call Customer Service at 1-866-465-0572 (TTY users call 711) and ask for the LIS Rider.

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

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

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 2027 handbook in the section called 2027 Medicare Costs. Download a copy from the Medicare website at (medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Some members are required to pay other Medicare premiums

You must have either Part A and/or Part B to be enrolled in a Part D plan. Although most people do not have to pay for Part A, some do. If you have to pay for Part A, you must also have Part B, and you must continue paying your Medicare premiums to stay a member of our plan.

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 generally 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. (For members who must pay a late enrollment penalty, the amount of the penalty will be added to the bill we send to you.) When you first enroll in our plan, we let you know the amount of the penalty.

Your Part D late enrollment penalty is considered part of your plan premium.

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 Part D or other 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.
- 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 2027, this average premium amount is $41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times $41.33, which equals $5.79. This rounds to $5.80. This amount would be added **to the plan sponsor's 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 generally 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 reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **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 generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

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 Amount (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 your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'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're 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 drug plan for your Part D prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any Part D prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

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

Section 5 More information about your monthly premium

Section 5.1 How to pay your plan premium (if applicable)

There are three ways you can pay your plan premium.

Option 1: Pay by check

We will send you a monthly bill for your monthly plan premium. Make your payment payable to UnitedHealthcare. Please see your monthly bill for the mailing address and other information. Include your member ID number on your check or money order. If making a payment for more than one member, include a payment slip for each member. Include the member ID number for each member on the check or money order. All payments must be received on or before the due date shown on the monthly bill. If you need your monthly bill replaced, please call Customer Service.

Option 2: Electronic Funds Transfer

Instead of paying by check, you can have your monthly plan premium automatically deducted from your checking account. Your monthly payment will be deducted around the 5th of each month. If you wish to sign up for Electronic Funds Transfer (EFT), you may follow the instructions on your monthly bill, or you may call Customer Service.

Option 3: Credit card

Instead of paying by check, you can pay your monthly plan premium with your credit card. If you wish to sign up to use your credit card to pay your monthly plan premium, please call Customer Service.

Changing the way you pay your plan premium. If you decide to change how you pay your plan premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your plan premium is paid on time. To change your payment method contact Customer Service for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Customer Service are printed on the cover of this booklet.)

If you have trouble paying your plan premium (if applicable)

Your plan premium is due in our office by the first day of the month. If we don't get your payment by the first day of the month, we'll send you a delinquency notice. In addition, we have the right to pursue collection of the amount you owe. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your premium on time, call Customer Service at 1-866-465-0572 (TTY users call 711) to see if we can direct you to programs that will help with your plan premium.

Section 5.2 Your monthly plan premium won't change (if applicable) during the year

We're not allowed to change our plan's monthly plan premium amount during the year.

Monthly plan premium changes and employer-sponsored benefit changes are subject to contractual arrangements between your plan sponsor and us, and as a result, monthly plan premiums generally do not change during the plan year. Your plan sponsor is responsible for notifying you of any monthly plan premium changes or retiree contribution changes (the portion of your monthly plan premium your plan sponsor requires you to pay) prior to the date when the change becomes effective.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of your plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premiums. If you lose your eligibility for Extra Help during the year, you'll need to start paying the full monthly premium. Find out more about Extra Help in Chapter 2, Section 7.

Section 6 Keep your plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage.

The pharmacists in our plan's network use your membership record to know what drugs are covered and the cost-sharing amounts. Because of this, it is very important you help to keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, let us know by calling Customer Service at 1-866-465-0572 (TTY users call 711).

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 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Service at 1-866-465-0572 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

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

Chapter 2:
Phone numbers and resources

Section 1 UnitedHealthcare® MedicareRx for Groups (PDP) contacts

For help with claims, billing, or UnitedHealthcare member ID card questions, call or write to Customer Service. We'll be happy to help you.

Customer Service - Contact Information	
Call	1-866-465-0572 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday Customer Service 1-866-465-0572 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	retiree.uhc.com

How to ask for a coverage decision or appeal

A coverage decision is a decision we make about your coverage or about the amount we 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 how to ask for coverage decisions or appeals about your Part D drugs, go to Chapter 7.

Coverage Decisions for Part D Prescription Drugs – Contact Information	
Call	1-866-465-0572

Coverage Decisions for Part D Prescription Drugs – Contact Information	
	Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	Optum Rx Prior Authorization Department P.O. Box 25183, Santa Ana, CA 92799
Website	retiree.uhc.com

Appeals for Part D Prescription Drugs – Contact Information	
Call	1-866-465-0572 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For fast/expedited appeals for Part D prescription drugs: 1-866-465-0572 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Fax	For standard Part D prescription drug appeals: 1-866-308-6294 For fast/expedited Part D prescription drug appeals: 1-866-308-6296
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA120-0368, Cypress, CA 90630-0016
Website	retiree.uhc.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.

Complaints about Part D Prescription Drugs – Contact Information	
Call	1-866-465-0572 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For fast/expedited complaints about Part D prescription drugs: 1-866-465-0572 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Fax	For standard Part D prescription drug complaints: 1-866-308-6294 For fast/expedited Part D prescription drug complaints: 1-866-308-6296
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA120-0368, Cypress, CA 90630-0016
Medicare website	To submit a complaint about UnitedHealthcare® MedicareRx for Groups (PDP) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

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 us 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.

Payment Requests – Contact Information	
Call	1-866-465-0572 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday

Payment Requests – Contact Information	
Write	Part D prescription drug payment requests: Optum Rx P.O. Box 650287, Dallas, TX 75265-0287
Website	retiree.uhc.com

Section 2 Get help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Prescription Drug Plans, including our plan.

Medicare – Contact Information	
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 difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. Because your coverage is provided by a plan sponsor, you will not find UnitedHealthcare® MedicareRx for Groups (PDP) plans listed on Medicare.gov. • 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.

Medicare – Contact Information	
	• 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 UnitedHealthcare® MedicareRx for Groups (PDP). **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. 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's a list of the State Health Insurance Assistance Programs in each state we serve:

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

- Illinois - Illinois Senior Health Insurance Program (SHIP)
- Indiana - Indiana State Health Insurance Assistance Program (SHIP)
- Iowa - Iowa Senior Health Insurance Information Program (SHIIP)
- Kansas - Kansas Senior Health Insurance Counseling for Kansas (SHICK)
- Kentucky - Kentucky State Health Insurance Assistance Program (SHIP)
- Louisiana - Louisiana Senior Health Insurance Information Program (SHIIP)
- Maine - Maine State Health Insurance Assistance Program (SHIP)
- Maryland - Maryland Department of Aging - Senior Health Insurance Assistance Program (SHIP)
- Massachusetts - Massachusetts Serving the Health Insurance Needs of Everyone (SHINE)
- Michigan - MI Options
- Minnesota - Minnesota State Health Insurance Assistance Program/Senior LinkAge Line
- Mississippi - Mississippi Department of Human Services, Division of Aging & Adult Services
- Missouri - Missouri State Health Insurance Assistance Program (SHIP)
- Montana - Montana State Health Insurance Assistance Program (SHIP)
- Nebraska - Nebraska Senior Health Insurance Information Program (SHIIP)
- Nevada - Nevada State Health Insurance Assistance Program (SHIP)
- New Hampshire - New Hampshire SHIP - ServiceLink Aging and Disability Resource Center
- New Jersey - New Jersey State Health Insurance Assistance Program (SHIP)
- New Mexico - New Mexico Benefits Counseling Program SHIP
- New York - New York Health Insurance Information Counseling and Assistance Program (HIICAP)
- North Carolina - North Carolina Seniors Health Insurance Information Program (SHIIP)
- North Dakota - North Dakota Senior Health Insurance Counseling (SHIC)
- Northern Mariana Islands - North Mariana Islands Senior Health Insurance Program
- Ohio - Ohio Senior Health Insurance Information Program (OSHIIP)
- Oklahoma - Oklahoma Medicare Assistance Program (MAP)
- Oregon - Oregon Senior Health Insurance Benefits Assistance (SHIBA)
- Pennsylvania - PA MEDI
- Puerto Rico - Puerto Rico State Health Insurance Assistance Program (SHIP)

- Rhode Island - Rhode Island State Health Insurance Assistance Program (SHIP)
- South Carolina - South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders
- South Dakota - South Dakota Senior Health Information & Insurance Education (SHIINE)
- Tennessee - Tennessee Commission on Aging & Disability - TN SHIP
- Texas - Texas Department of Aging and Disability Services (HICAP)
- Utah - Utah Senior Health Insurance Information Program (SHIP)
- Vermont - Vermont State Health Insurance Assistance Program (SHIP)
- Virgin Islands of the U.S. - Virgin Islands State Health Insurance Assistance Program (VISHIP)
- Virginia - Virginia Insurance Counseling and Assistance Program (VICAP)
- Washington - Washington Statewide Health Insurance Benefits Advisors (SHIBA)
- West Virginia - West Virginia State Health Insurance Assistance Program (WV SHIP)
- Wisconsin - Wisconsin State Health Insurance Plan (SHIP)
- Wyoming - Wyoming State Health Insurance Information Program (WSHIIP)

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

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

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Alabama | Alabama State Health Insurance Assistance Program (SHIP) 201 Monroe ST, STE 350 Montgomery, AL 36104 www.alabamaageline.gov	1-877-425-2243 TTY 711
Alaska | Alaska Medicare Information Office 3601 C Street, Suite 902 Anchorage, AK 99503 https://health.alaska.gov/en/senior-and-disabilities-services/	1-907-269-3666 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
American Samoa | American Samoa Senior Health Insurance Program ASTCA Executive BLDG #306, P.O. Box 6101 Pago Pago, AS 96799 https://www.medicaid.gov/state-overviews/american-samoa.html	1-684-699-4777 TTY 711
Arizona | Arizona State Health Insurance Assistance Program 1366 E Thomas RD, STE 108 ATTN: SHIP Phoenix, AZ 85014 https://des.az.gov/services/older-adults/medicare-assistance	1-800-432-4040 TTY 711
Arkansas | Arkansas Senior Health Insurance Information Program (SHIIP) 1 Commerce Way Little Rock, AR 72202 https://insurance.arkansas.gov/consumer-services/senior-health/	1-800-224-6330 TTY 711
California | California Health Insurance Counseling & Advocacy Program (HICAP) 2880 Gateway Oaks Dr, STE 200 Sacramento, CA 95833 https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/	1-800-434-0222 TTY 1-800-735-2929
Colorado | Colorado Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, STE 850 Denver, CO 80202 https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare	1-888-696-7213 TTY 711
Connecticut | Connecticut CHOICES Senior Health Insurance Program 55 Farmington AVE, FL 12 Hartford, CT 06105-3730 https://portal.ct.gov/ads/programs-and-services/choices?language=en_US	1-800-994-9422 TTY 711
Delaware | Delaware Medicare Assistance Bureau (DMAB) 1351 West North ST, STE 101 Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	1-800-336-9500 TTY 711
District of Columbia | DC State Health Insurance Assistance Program (SHIP) 250 E Street SW Washington, DC 20024 dacl.dc.gov/service/health-insurance-counseling	1-202-727-8370 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Florida | Florida Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, STE 270 Tallahassee, FL 32399-7000 www.floridashine.org	1-800-963-5337 TTY 1-800-955-8770
Georgia | GeorgiaCares Senior Health Insurance Plan 47 Trinity Ave. S.W. Atlanta, GA 30334 https://aging.georgia.gov/georgiacares-ship	1-866-552-4464 TTY 711
Guam | Guam Medicare Assistance Program (GUAM MAP) 130 University DR, STE 8, University Castle Mall Mangilao, GU 96913 http://dphss.guam.gov/	1-671-735-7421 TTY 1-671-735-7415
Hawaii | Hawaii SHIP No. 1 Capitol District, 250 S Hotel ST, STE 406 Honolulu, HI 96813-2831 www.hawaiiship.org	1-888-875-9229 TTY 1-866-810-4379
Idaho | Idaho Senior Health Insurance Benefits Advisors (SHIBA) 700 W State St Boise, ID 83720 http://www.doi.idaho.gov/SHIBA/	1-800-247-4422 TTY 711
Illinois | Illinois Senior Health Insurance Program (SHIP) 1 Natural Resources Way, STE 100 Springfield, IL 62702-1271 https://ilaging.illinois.gov/	1-800-252-8966 TTY 711
Indiana | Indiana State Health Insurance Assistance Program (SHIP) 311 W Washington ST, STE 200 Indianapolis, IN 46204-2787 http://www.in.gov/ship	1-800-452-4800 TTY 1-866-846-0139
Iowa | Iowa Senior Health Insurance Information Program (SHIIP) 1963 Bell Avenue, STE 100 Des Moines, IA 50315 shiip.iowa.gov	1-800-351-4664 TTY 1-800-735-2942
Kansas | Kansas Senior Health Insurance Counseling for Kansas (SHICK) New England BLDG, 503 S Kansas AVE Topeka, KS 66603-3404 https://www.kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick	1-800-860-5260 TTY 1-785-291-3167

State Health Insurance Assistance Programs (SHIP) – Contact Information	
Kentucky | Kentucky State Health Insurance Assistance Program (SHIP) 275 E Main ST, 3E-E Frankfort, KY 40601 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	1-877-293-7447 TTY 1-800-627-4702
Louisiana | Louisiana Senior Health Insurance Information Program (SHIIP) 1702 N. Third Street Baton Rouge, LA 70802 http://www.ldi.la.gov/SHIIP/	1-800-259-5300 TTY 711
Maine | Maine State Health Insurance Assistance Program (SHIP) 109 Capitol Street Augusta, ME 04333 https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	1-207-287-3707 TTY 711
Maryland | Maryland Department of Aging - Senior Health Insurance Assistance Program (SHIP) 36 S Charles St, FL 12 Baltimore, MD 21201 https://aging.maryland.gov/Pages/state-health-insurance-program.aspx	1-800-243-3425 TTY 711
Massachusetts | Massachusetts Serving the Health Insurance Needs of Everyone (SHINE) 1 Ashburton PL, RM 517 Boston, MA 02108 www.mass.gov/health-insurance-counseling	1-800-243-4636 TTY 1-800-439-2370
Michigan | MI Options P.O. Box 30676 Lansing, MI 48909 www.michigan.gov/MDHHSMIOptions	1-800-803-7174 TTY 711
Minnesota | Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar Street St. Paul, MN 55164-0976 https://mn.gov/senior-linkage-line	1-800-333-2433 TTY 1-800-627-3529
Mississippi | Mississippi Department of Human Services, Division of Aging & Adult Services 200 S Lamar ST Jackson, MS 39201 https://www.mdhs.ms.gov/aging/finding-services-for-older-adults/	1-601-359-4500 TTY 711
Missouri | Missouri State Health Insurance Assistance Program (SHIP)	1-800-390-3330 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
601 W Nifong Blvd, STE 3A Columbia, MO 65203 https://www.missouriship.org	
Montana | Montana State Health Insurance Assistance Program (SHIP) 1100 N Last Chance Gulch, FL 4 Helena, MT 59601 http://dphhs.mt.gov/sltc/aging/ship	1-800-551-3191 TTY 711
Nebraska | Nebraska Senior Health Insurance Information Program (SHIIP) 1526 K Street, Suite 201 Lincoln, NE 68508 https://doi.nebraska.gov/consumer/senior-health	1-800-234-7119 TTY 711
Nevada | Nevada State Health Insurance Assistance Program (SHIP) 1550 College Parkway Carson City, NV 89706 https://adsd.nv.gov/Programs/Seniors/Medicare_Assistance_Program_(MAP)/MAP_Prog/	1-800-307-4444 TTY 711
New Hampshire | New Hampshire SHIP - ServiceLink Aging and Disability Resource Center 25 Roxbury St, STE 106 Keene, NH 03431 https://www.servicelink.nh.gov	1-866-634-9412 TTY 1-800-735-2964
New Jersey | New Jersey State Health Insurance Assistance Program (SHIP) P.O. Box 807 Trenton, NJ 08625 www.nj.gov/humanservices/doas/services/q-z/ship/index.shtml	1-800-792-8820 TTY 711
New Mexico | New Mexico Benefits Counseling Program SHIP 2250 Cerrillos Rd Santa Fe, NM 87505 https://www.aging.nm.gov/consumer-and-elder-rights/medicare/	1-800-432-2080 TTY 1-505-476-4937
New York | New York Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza, FL 5 Albany, NY 12223 www.aging.ny.gov/health-insurance-information-counseling-and-assistance	1-800-701-0501 TTY 711
North Carolina | North Carolina Seniors Health Insurance Information Program (SHIIP) 1201 Mail Service Center Raleigh, NC 27699-1201 http://www.ncdoi.gov/SHIIP	1-855-408-1212 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
North Dakota | North Dakota Senior Health Insurance Counseling (SHIC) 600 E BLVD AVE Bismarck, ND 58505-0320 https://www.insurance.nd.gov/consumers/medicare	1-888-575-6611 TTY 711
Northern Mariana Islands | North Mariana Islands Senior Health Insurance Program P.O. Box 5795 CHRB Saipan, MP 96950 http://commerce.gov.mp/	1-670-664-3000 TTY 711
Ohio | Ohio Senior Health Insurance Information Program (OSHIIP) 50 W Town ST, STE 300, FL 3 Columbus, OH 43215 https://insurance.ohio.gov/wps/portal/gov/odi/consumers	1-800-686-1578 TTY 1-614-644-3745
Oklahoma | Oklahoma Medicare Assistance Program (MAP) 400 NE 50th ST Oklahoma City, OK 73105 www.map.oid.ok.gov	1-800-763-2828 TTY 711
Oregon | Oregon Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter St NE Salem, OR 97309 oregonshiba.org	1-800-722-4134 TTY 711
Pennsylvania | PA MEDI 555 Walnut ST, FL 5 Harrisburg, PA 17101-1919 aging.pa.gov	1-800-783-7067 TTY 711
Puerto Rico | Puerto Rico State Health Insurance Assistance Program (SHIP) Ponce de León AVE, PDA 16, EDIF 1064, 3er nivel San Juan, PR 00919-1179 www.oppea.pr.gov	1-787-721-6121 TTY 711
Rhode Island | Rhode Island State Health Insurance Assistance Program (SHIP) 25 Howard AVE, BLDG 57 Cranston, RI 02920 https://oha.ri.gov/Medicare	1-888-884-8721 TTY 1-401-462-0740
South Carolina | South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais ST, STE 350 Columbia, SC 29201 https://aging.sc.gov/	1-800-868-9095 TTY 711

State Health Insurance Assistance Programs (SHIP) – Contact Information	
South Dakota | South Dakota Senior Health Information & Insurance Education (SHIINE) 3800 E. Hwy 34 - Hillsview Pl c/o 500 E. Capitol Ave Pierre, SD 57501 www.shiine.net	1-800-265-9684 TTY 711
Tennessee | Tennessee Commission on Aging & Disability - TN SHIP Davy Crockett Tower, 2nd Floor, 500 James Robertson Pkwy Nashville, TN 37243 https://www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html	1-877-801-0044 TTY 1-800-848-0299
Texas | Texas Department of Aging and Disability Services (HICAP) P.O. Box 13247 Austin, TX 78711 https://hhs.texas.gov/services/health/medicare	1-800-252-9240 TTY 711
Utah | Utah Senior Health Insurance Information Program (SHIP) 288 N. 1460 West Salt Lake City, UT 84116 https://daas.utah.gov	1-877-424-4640 TTY 711
Vermont | Vermont State Health Insurance Assistance Program (SHIP) 27 Main Street, Suite 14 Montpelier, VT 05602 www.vermont4a.org	1-800-642-5119 TTY 711
Virgin Islands of the U.S. | Virgin Islands State Health Insurance Assistance Program (VISHIP) 1131 King ST, STE 101 St. Croix, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	1-340-773-6449 TTY 711
Virginia | Virginia Insurance Counseling and Assistance Program (VICAP) 5620 Cox Rd Glen Allen, VA 23060 dars.virginia.gov/aging/home-community/medicare-counseling/	1-804-662-9333 TTY 1-800-552-3402
Washington | Washington Statewide Health Insurance Benefits Advisors (SHIBA) P.O. Box 40255 Olympia, WA 98504-0255 www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba	1-800-562-6900 TTY 1-360-586-0241

State Health Insurance Assistance Programs (SHIP) – Contact Information	
West Virginia | West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha BLVD E Charleston, WV 25305 www.wvship.org	1-877-987-4463 TTY 711
Wisconsin | Wisconsin State Health Insurance Plan (SHIP) 1402 Pankratz ST, STE 111 Madison, WI 53704 www.longtermcare.wi.gov	1-800-242-1060 TTY 711
Wyoming | Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams AVE Riverton, WY 82501 www.wyomingseniors.com	1-800-856-4398 TTY 711

Section 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. Here's a list of the Quality Improvement Organizations in each state we serve:

- Alabama - ACENTRA
- Alaska - ACENTRA
- American Samoa - Commence Health BFCC-QIO Program
- Arizona - Commence Health BFCC-QIO Program
- Arkansas - ACENTRA
- California - Commence Health BFCC-QIO Program
- Colorado - ACENTRA
- Connecticut - ACENTRA
- Delaware - Commence Health BFCC-QIO Program
- District of Columbia - Commence Health BFCC-QIO Program
- Florida - ACENTRA
- Georgia - ACENTRA
- Guam - Commence Health BFCC-QIO Program
- Hawaii - Commence Health BFCC-QIO Program

- Idaho - ACENTRA
- Illinois - Commence Health BFCC-QIO Program
- Indiana - Commence Health BFCC-QIO Program
- Iowa - Commence Health BFCC-QIO Program
- Kansas - Commence Health BFCC-QIO Program
- Kentucky - ACENTRA
- Louisiana - ACENTRA
- Maine - ACENTRA
- Maryland - Commence Health BFCC-QIO Program
- Massachusetts - ACENTRA
- Michigan - Commence Health BFCC-QIO Program
- Minnesota - Commence Health BFCC-QIO Program
- Mississippi - ACENTRA
- Missouri - Commence Health BFCC-QIO Program
- Montana - ACENTRA
- Nebraska - Commence Health BFCC-QIO Program
- Nevada - Commence Health BFCC-QIO Program
- New Hampshire - ACENTRA
- New Jersey - Commence Health BFCC-QIO Program
- New Mexico - ACENTRA
- New York - Commence Health BFCC-QIO Program
- North Carolina - ACENTRA
- North Dakota - ACENTRA
- Northern Mariana Islands - Commence Health BFCC-QIO Program
- Ohio - Commence Health BFCC-QIO Program
- Oklahoma - ACENTRA
- Oregon - ACENTRA
- Pennsylvania - Commence Health BFCC-QIO Program
- Puerto Rico - Commence Health BFCC-QIO Program

- Rhode Island - ACENTRA
- South Carolina - ACENTRA
- South Dakota - ACENTRA
- Tennessee - ACENTRA
- Texas - ACENTRA
- Utah - ACENTRA
- Vermont - ACENTRA
- Virgin Islands of the U.S. - Commence Health BFCC-QIO Program
- Virginia - Commence Health BFCC-QIO Program
- Washington - ACENTRA
- West Virginia - Commence Health BFCC-QIO Program
- Wisconsin - Commence Health BFCC-QIO Program
- Wyoming - ACENTRA

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

Contact your state's Quality Improvement Organization if you have a complaint about the quality of care you got. For example, you can contact the Quality Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

Quality Improvement Organization (QIO) – Contact Information	
Alabama | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0751 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Alaska | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-305-6759 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
American Samoa | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-684-699-3330 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Arizona | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-877-588-1123 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Arkansas | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-315-0636 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
California | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-877-588-1123 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Colorado | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0891 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Connecticut | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-319-8452 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
Delaware | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-396-4646 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
District of Columbia | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-396-4646 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Florida | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0751 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Georgia | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0751 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Guam | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-671-685-2689 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Hawaii | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-877-588-1123 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
Idaho | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-305-6759 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Illinois | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-524-9900 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Indiana | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-524-9900 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Iowa | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-755-5580 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Kansas | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-755-5580 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Kentucky | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0751 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
Louisiana | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-315-0636 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Maine | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-319-8452 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Maryland | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-396-4646 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Massachusetts | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-319-8452 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Michigan | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-524-9900 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Minnesota | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-524-9900 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
Mississippi | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0751 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Missouri | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-755-5580 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Montana | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0891 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Nebraska | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-755-5580 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Nevada | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-877-588-1123 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
New Hampshire | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-319-8452 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
New Jersey | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-866-815-5440 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
New Mexico | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-315-0636 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
New York | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-866-815-5440 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
North Carolina | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0751 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
North Dakota | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0891 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Northern Mariana Islands | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-670-989-2686 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
Ohio | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-524-9900 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Oklahoma | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-315-0636 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Oregon | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-305-6759 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Pennsylvania | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-396-4646 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Puerto Rico | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-787-520-5743 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Rhode Island | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-319-8452 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
South Carolina | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0751 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
South Dakota | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0891 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Tennessee | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0751 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Texas | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-315-0636 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Utah | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0891 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Vermont | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-319-8452 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays
Virgin Islands of the U.S. | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-340-773-6334 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Virginia | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-396-4646 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Washington | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-305-6759 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
West Virginia | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-396-4646 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Wisconsin | Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov/	1-888-524-9900 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4 p.m. local time, weekends and holidays
Wyoming | ACENTRA 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com	1-888-317-0891 TTY 711 9 a.m.-5 p.m. local time, Monday-Friday, 10 a.m.-4

Quality Improvement Organization (QIO) – Contact Information	
	p.m. local time, weekends and holidays

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

Section 6 Medicaid

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

Medicaid. 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+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

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

State Medicaid Programs – Contact Information	
Alabama | Alabama Medicaid P.O. Box 5624 Montgomery, AL 36103-5624 http://www.medicaid.alabama.gov/	1-800-362-1504 TTY 1-800-253-0799 8 a.m.-4:30 p.m. CT, Monday-Friday
Alaska | State of Alaska Department of Health & Social Services, Division of Health Care Services 855 W Commercial Drive, STE 131 Wasilla, AK 99654 http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx	1-800-478-7778 TTY 711 8 a.m.-5 p.m. AKT, Monday-Friday
American Samoa | American Samoa Medicaid State Agency ASCTA Executive BLDG #306, P.O. Box 6101 Pago Pago, AS 96799 http://medicaid.as.gov/	1-684-699-4777 TTY 711 7:30 a.m.-4 p.m. ST, Monday-Friday
Arizona | Arizona Health Care Cost Containment System (AHCCCS) 150 N 18th Ave Phoenix, AZ 85007 www.azahcccs.gov	1-602-417-4000 TTY 1-800-654-8713 8 a.m.-5 p.m. MT, Monday-Friday
Arkansas | Arkansas Division of Medical Services Department of Human Services Donaghey Plaza S, P.O. Box 1437, Slot S401 Little Rock, AR 72203 https://humanservices.arkansas.gov/	1-800-482-5434 TTY 1-501-682-8820 8 a.m.-4:30 p.m. CT, Monday-Friday

State Medicaid Programs – Contact Information	
California | Medi-Cal - Managed Care Operations Division Department of Health Care Services P.O. Box 989009 West Sacramento, CA 95798-9850 https://www.healthcareoptions.dhcs.ca.gov/	1-800-430-4263 TTY 1-800-430-7077 8 a.m.-5 p.m. PT, Monday-Friday
Colorado | Colorado Department of Health Care Policy and Financing 303 E 17th Avenue Denver, CO 80203 www.healthfirstcolorado.com	1-800-221-3943 TTY 711 8 a.m.-4:30 p.m. MT, Monday-Friday
Connecticut | HUSKY Health Program 55 Farmington Ave Hartford, CT 06105-3730 www.ct.gov/dss	1-800-842-4524 TTY 1-800-842-4524 8:30 a.m.-4:30 p.m. local time, Monday-Friday
Delaware | Delaware Health and Social Services 1901 N Dupont HWY, Lewis BLDG New Castle, DE 19720 http://dhss.delaware.gov/dhss/	1-302-255-9040 TTY 711 8 a.m.-4:30 p.m. ET, Monday-Friday
District of Columbia | DC Department of Human Services 441 4th ST NW, 900S Washington, DC 20001 dhcf.dc.gov	1-202-442-9533 TTY 711 9 a.m.-4:45 p.m. ET, Monday-Friday
Florida | Florida Medicaid Agency for Health Care Administration (AHCA) 2727 Mahan DR, MS 6 Tallahassee, FL 32308 https://ahca.myflorida.com/	1-888-419-3456 TTY 1-800-955-8771 8 a.m.-5 p.m. ET, Monday-Friday
Georgia | Georgia Department of Community Health 2 Martin Luther King Jr DR SE, E Tower Atlanta, GA 30334 https://medicaid.georgia.gov/	1-404-656-4507 TTY 711 8 a.m.-5 p.m. ET, Monday-Friday
Guam | Guam Department of Public Health and Social Services Bureau of Health Care Financing	1-671-735-7352 TTY 711 8 a.m.-5 p.m. CHT, Monday-Friday

State Medicaid Programs – Contact Information	
123 Chalan Kareta Mangilao, GU 96913-6304 http://www.dphss.guam.gov/	
Hawaii | Department of Human Services 1390 Miller ST, RM 209 Honolulu, HI 96813 https://humanservices.hawaii.gov/	1-808-586-4993 TTY 711 7:45 a.m.-4:30 p.m. HT, Monday-Friday
Idaho | Idaho Department of Health and Welfare 1720 Westgate Dr. Boise, ID 83704 https://healthandwelfare.idaho.gov	1-877-456-1233 TTY 1-888-791-3004 8 a.m.-5 p.m. MT, Monday-Friday
Illinois | Illinois Department of Healthcare and Family Services 100 S Grand AVE E Springfield, IL 62704 http://www2.illinois.gov/hfs/	1-800-843-6154 TTY 1-800-447-6404 8:30 a.m.-7 p.m. CT, Monday-Friday
Indiana | Indiana Family and Social Services Administration FSSA Document CTR, P.O. Box 1810 Marion, IN 46952 www.in.gov/fssa/dfr/	1-800-403-0864 TTY 1-800-743-3333 8 a.m.-4:30 p.m. local time, Monday-Friday
Iowa | Department of Human Services 321 East 12th Street Des Moines, IA 50319 https://hhs.iowa.gov/programs/welcome-iowa-medicaid	1-800-338-8366 TTY 1-800-735-2942 8 a.m.-4:30 p.m. local time, Monday-Friday
Kansas | Kansas Dept. of Health and Environment 900 SW Jackson ST Topeka, KS 66612 http://www.kancare.ks.gov/	1-800-792-4884 TTY 711 8 a.m.-5 p.m. CT, Monday-Friday
Kentucky | Kentucky Cabinet for Health and Family Services 275 E Main ST Frankfort, KY 40621 https://chfs.ky.gov/	1-800-635-2570 TTY 711 8 a.m.-5 p.m. ET, Monday-Friday
Louisiana | Louisiana Department of Health 628 N. 4th Street Baton Rouge, LA 70802 https://ldh.la.gov/	1-225-342-9500 TTY 711 8 a.m.-4:30 p.m. local time, Monday-Friday

State Medicaid Programs – Contact Information	
Maine | Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms/	1-800-977-6740 TTY 711 8 a.m.-5 p.m. ET, Monday-Friday
Maryland | Maryland Department of Health, HealthChoice 201 W Preston ST Baltimore, MD 21201-2399 https://health.maryland.gov/Pages/Home.aspx	1-877-463-3464 TTY 1-800-735-2258 8:30a.m.-5 p.m. ET, Monday-Friday
Massachusetts | Massachusetts Office of Health and Human Services 55 Summer Street Boston, MA 02110 http://www.mass.gov/eohhs/gov/departments/masshealth/	1-800-841-2900 TTY 711 8 a.m.-5 p.m. ET, Monday-Friday
Michigan | Department of Health and Human Services P.O. Box 30479 Lansing, MI 48909 Beneficiary Support	1-800-642-3195 TTY 1-800-649-3777 8 a.m.-7 p.m. Monday-Friday (except holidays)
Minnesota | Minnesota Department of Human Services P.O. Box 64989 St. Paul, MN 55164-0989 http://mn.gov/dhs	1-800-657-3739 TTY 1-800-627-3529 8 a.m.-5 p.m. CT, Monday-Friday
Mississippi | State of Mississippi Division of Medicaid 550 High ST STE, 1000 Sillers BLDG Jackson, MS 39201-1399 http://www.medicaid.ms.gov/	1-800-421-2408 TTY 711 7:30 a.m.-5 p.m. CT, Monday-Friday
Missouri | MO HealthNet Division Department of Social Services 615 Howerton CT, P.O. Box 6500 Jefferson City, MO 65102-6500 https://www.dss.mo.gov/mhd/	1-573-526-4274 TTY 1-800-735-2966 8 a.m.-5 p.m. CT, Monday-Friday
Montana | Montana Healthcare Programs 1400 E Broadway, Room A206 Helena, MT 59601-5231 https://dphhs.mt.gov/MontanaHealthcarePrograms	1-888-362-8312 TTY 1-800-833-8503 8 a.m.-5 p.m. MT, Monday-Friday

State Medicaid Programs – Contact Information	
Nebraska | Nebraska Department of Health and Human Services P.O. Box 95026 Lincoln, NE 68509-5026 dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx	1-402-471-3121 TTY 1-800-471-7352 8 a.m.-5 p.m. CT, Monday-Friday
Nevada | Nevada Health Authority 2310 S Carson St Carson City, NV 89701 http://dhcfp.nv.gov	1-866-569-1746 TTY 711 8 a.m.-5 p.m. PT, Monday-Friday
New Hampshire | New Hampshire Department of Health and Human Services 129 Pleasant ST Concord, NH 03301-3852 https://www.dhhs.nh.gov/ombp/medicaid/	1-844-275-3447 TTY 1-800-735-2964 8 a.m.-4 p.m. ET, Monday-Friday
New Jersey | Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625-0712 https://www.state.nj.us/humanservices/dmahs/	1-800-701-0710 TTY 711 8 a.m.-8 p.m. ET, Monday and Thursday, 8 a.m.-5 p.m. ET, Tuesday, Wednesday and Friday
New Mexico | Health Care Authority P.O. Box 2348 Santa Fe, NM 87504-2348 https://www.hca.nm.gov/	1-800-283-4465 TTY 711 7 a.m.-6:30 p.m. MT, Monday-Friday
New York | New York State Medicaid Program Corning Tower, Empire State Plaza Albany, NY 12237 www.health.ny.gov/health_care/medicaid/ldss	1-800-541-2831 TTY 711 Monday-Friday 8 a.m.-8 p.m. ET, Saturday 9 a.m.-1 p.m. ET
North Carolina | North Carolina Department of Health and Human Services 1915 Health Services Way Raleigh, NC 27607 https://www.ncdhhs.gov/	1-888-245-0179 TTY 711 8 a.m.-5 p.m. ET, Monday-Friday
North Dakota | North Dakota Department of Human Services 600 E Boulevard Ave., Dept. 325 Bismarck, ND 58505-0250 https://www.hhs.nd.gov/healthcare/medicaid	1-866-614-6005 TTY 711 8 a.m.-5 p.m. CT, Monday-Friday

State Medicaid Programs – Contact Information	
Northern Mariana Islands | State Medicaid Administration Office Government BLDG #1252, Capital Hill RD, Caller Box 100007 Saipan, MP 96950 http://medicaid.cnmi.mp/	1-670-664-4880 TTY 711 7:30 a.m.-1 p.m. CHT, Monday-Thursday
Ohio | Ohio Department of Medicaid 50 W Town ST, STE 400 Columbus, OH 43215 https://medicaid.ohio.gov/	1-800-324-8680 TTY 711 7 a.m.-8 p.m. ET, Monday-Friday, 8 a.m.-5 p.m. ET, Saturday
Oklahoma | Oklahoma Health Care Authority 4345 N Lincoln BLVD Oklahoma City, OK 73105 https://www.oklahoma.gov/ohca.html	1-800-987-7767 TTY 711 8 a.m.-5 p.m. CT, Monday-Friday
Oregon | Oregon Health Authority 500 Summer ST, NE, E-20 Salem, OR 97301-1097 https://www.oregon.gov/oha/HSD/OHP	1-503-947-2340 TTY 711 8 a.m.-5 p.m. PT, Monday-Friday
Pennsylvania | Office of Medical Assistance Programs (OMAP) PO Box 2675 Harrisburg, PA 17105 https://www.pa.gov/en/agencies/dhs/resources/medicaid.html	1-800-692-7462 TTY 1-800-451-5886 8 a.m.-4:45 p.m. ET, Monday-Friday
Puerto Rico | Government of Puerto Rico, Department of Health Medicaid Program P.O. Box 70184 San Juan, PR 00936-8184 https://medicaid.pr.gov	1-787-765-2929 TTY 1-787-625-6955 8 a.m.-5 p.m. ET, Monday-Friday
Rhode Island | Rhode Island Department of Human Services (DHS) PO Box 8709 Cranston, RI 02920-8787 www.dhs.ri.gov	1-855-697-4347 TTY 711 8:30 a.m. - 3 p.m. ET, Monday, Tuesday, Thursday and Friday
South Carolina | South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206 http://www.scdhhs.gov/	1-888-549-0820 TTY 1-888-842-3620 8 a.m.-6 p.m. ET, Monday-Friday
South Dakota | South Dakota Department of Social Services, Division of Medical Services	1-605-773-4678 TTY 711 8 a.m.-5 p.m. local time, Monday-Friday

State Medicaid Programs – Contact Information	
700 Governors DR Pierre, SD 57501 http://dss.sd.gov/medicaid/	
Tennessee | Division of TennCare 310 Great Circle RD Nashville, TN 37243 https://www.tn.gov/tenncare/	1-855-259-0701 TTY 1-800-848-0299 8 a.m.-4:30 p.m. CT, Monday-Friday
Texas | Texas Medicaid Health and Human Services Commission P. O. Box 13247 Austin, TX 78711-3247 www.yourtexasbenefits.com	1-877-541-7905 TTY 711 8 a.m.-6 p.m. CST, Monday-Friday
Utah | Utah Department of Health, Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 https://medicaid.utah.gov/	1-800-662-9651 TTY 711 8 a.m.-5 p.m. MT, Monday-Friday, 8 a.m.-11 a.m. MT, Thursday
Vermont | Department of Vermont Health Access 280 State Drive, NOB 1 South South Waterbury, VT 05671-1010 http://www.greenmountaincare.org/	1-800-250-8427 TTY 711 8 a.m.-5 p.m. ET, Monday-Friday
Virgin Islands of the U.S. | U.S. Virgin Islands Bureau of Health Insurance & Medical Assistance 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 https://dhs.vi.gov/office-of-medicaid/	1-340-774-0930 TTY 711 8 a.m.-5 p.m. ET, Monday-Friday
Virginia | Virginia Department of Medical Assistance Services 600 E Broad ST Richmond, VA 23219 www.virginiamanagedcare.com/en	1-800-643-2273 TTY 1-800-817-6608 8 a.m.-6 p.m. ET, Monday-Friday
Washington | Washington State Health Care Authority P.O. Box 45531 Olympia, WA 98504 hca.wa.gov/free-or-low-cost-health-care	1-800-562-3022 TTY 711 7 a.m.-5 p.m. PT, Monday-Friday
West Virginia | West Virginia Bureau for Medical Services	1-304-558-1700 TTY 711 8:30 a.m.-5 p.m. ET, Monday-Friday

State Medicaid Programs – Contact Information	
350 Capitol ST, RM 251 Charleston, WV 25301 https://bms.wv.gov/about-us	
Wisconsin | Wisconsin Department of Health Services 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/health-care-coverage/index.htm	1-800-362-3002 TTY 711 8 a.m.-6 p.m. CT, Monday-Friday
Wyoming | Wyoming Department of Health 122 W 25th St., 4th FL West Cheyenne, WY 82001 http://health.wyo.gov/healthcarefin/medicaid/	1-307-777-7531 TTY 1-855-329-5205 9 a.m.-5 p.m. MT, Monday-Friday

Section 7 Programs to help people pay for prescription drugs

The Medicare website (Medicare.gov/basics/costs/help/drug-costs) has information on ways 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 plan 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. If you don't automatically qualify, you can apply any time. To see if you qualify for getting Extra Help:

- Visit secure.ssa.gov/i1020/start to apply online
- Call Social Security at 1-800-772-1213. TTY users 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.

- Please call the customer service number in Chapter 2 Section 1. Our Customer Service 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 the payment directly to the state. Call Customer Service 1-866-465-0572 (TTY users call 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 its rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE

(1-800-633-4227) and say "Medicaid" for more information. TTY users 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're 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)?

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

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, please 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 the state ADAP office listed below.

AIDS Drug Assistance Program (ADAP) – Contact Information

Alabama | Alabama AIDS Drug Assistance Program Office of HIV Prevention and Care, 201 Monroe ST, STE 1200 Montgomery, AL 36104 http://www.alabamapublichealth.gov/hiv/adap.html	1-866-574-9964 8 a.m.-5 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Alaska | Alaskan AIDS Assistance Association 1057 W Fireweed LN, STE 102 Anchorage, AK 99503 http://www.alaskanaids.org/index.php/client-services/adap	1-907-263-2050 9 a.m.-5 p.m. local time, Monday-Friday
American Samoa | American Samoa Department of Health HIV/STD/TB/Viral Hepatitis Baby George Building Fagaima, AS 96799 https://doh.as/divisions/	1-684-699-0649 8 a.m.-5 p.m. local time, Monday-Friday
Arizona | Arizona Department of Health ServicesOffice of Disease Integration & Services 150 N 18th AVE, STE 280 Phoenix, AZ 85007 https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/std-control/index.php#resources-providers	1-602-364-4571 8 a.m.-5 p.m. local time, Monday-Friday
Arkansas | Arkansas AIDS Drug Assistance Program (ADAP) Ryan White Program 4815 W Markham ST, Slot 33 Little Rock, AR 72205 https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/ryan-white-program/	1-501-661-2408 8 a.m.-4:30 p.m. local time, Monday-Friday
California | Office of AIDS Center for Infectious Diseases California Department of Public Health P.O. Box 997426, MS 7700 Sacramento, CA 95899-7426 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx	1-916-449-5900 8 a.m.-5 p.m. local time, Monday-Friday
Colorado | Colorado State Drug Assistance Program (SDAP) 4300 Cherry Creek DR S Denver, CO 80246-1530 https://cdphe.colorado.gov/state-drug-assistance-program	1-303-692-2000 9 a.m.-5 p.m. local time, Monday-Friday
Connecticut | Connecticut ADAP (CADAP) State of CT Department of Public Health c/o Prime Therapeutics Management P.O. Box 13001 Albany, NY 12212-3001 https://ctdph.primetherapeutics.com/	1-800-424-3310 8 a.m.-4 p.m. local time, Monday-Friday
Delaware | Delaware Division of Public Health Ryan White Program 540 S DuPont HWY Dover, DE 19901 http://www.dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html	1-302-744-1050 8 a.m.-4:30 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
District of Columbia | DC Pharmacy Benefits Program AIDS Drug Assistance Program (ADAP)2201 Shannon Place SE Washington, DC 20020 https://dchealth.dc.gov/node/137072	1-202-442-5955 8:15 a.m.-4:45 p.m. local time, Monday-Friday
Florida | Florida Department of Health ADAP HIV/AIDS Section, 4052 Bald Cypress Way Tallahassee, FL 32399 http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	1-844-381-2327 8 a.m.-9 p.m. local time, Monday-Friday
Georgia | Georgia AIDS Drug Assistance Program (ADAP) 200 Piedmont Ave., SE Atlanta, GA 30303-3186 https://dph.georgia.gov/health-topics/office-hivaids/hiv-care/aids-drug-assistance-program-adap	1-404-656-9805 8 a.m.-5 p.m. local time, Monday-Friday
Guam | Bureau of Communicable Disease Control - STD/HIV/Viral Hepatitis Program 520 West Santa Monica Avenue, RM 126 Dededo, GU 96913 https://dphss.guam.gov/	1-671-735-7143 8 a.m.-5 p.m. local time, Monday-Friday
Hawaii | Hawaii State Department of Health Harm Reduction Services Branch 3627 Kilauea AVE, STE 306 Honolulu, HI 96816 https://health.hawaii.gov/harmreduction/	1-808-733-8443 7:45 a.m.-4:30 p.m. local time, Monday-Friday
Idaho | Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, FL 4 Boise, ID 83720-0036 https://healthandwelfare.idaho.gov/health-wellness/diseases-conditions/human-immunodeficiency-virus-hiv	1-208-985-3019 8 a.m.-5 p.m. local time, Monday-Friday
Illinois | Illinois ADAP 525 W Jefferson ST, FL 1 Springfield, IL 62761 https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services	1-800-825-3518 8:30 a.m.-4:00 p.m. local time, Monday-Friday
Indiana | Indiana HIV Services Program 2 N Meridian ST, STE 6C Indianapolis, IN 46206 https://www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/	1-866-588-4948 8:15 a.m.-4:45 p,m, local time Monday-Friday
Iowa | Iowa Benefits and Drug Assistance Program (BDAP) 321 E 12th ST Des Moines, IA 50319-0075 https://hhs.iowa.gov/health-prevention/hiv-sti-and-hepatitis/hivaids-program	1-515-204-3746 8 a.m.-4:30 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Kansas | Kansas AIDS Drug Assistance Program 1000 SW Jackson ST, STE 540 Topeka, KS 66612 https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program	1-785-296-1086 8 a.m.-5 p.m. local time, Monday-Friday
Kentucky | Kentucky AIDS Drug Assistance Program (KADAP) HIV/AIDS Branch, 275 E Main ST, HS2E-C Frankfort, KY 40621 https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	1-502-564-6539 8 a.m.-4:30 p.m. local time, Monday-Friday
Louisiana | Louisiana Health Access Program (LAHAP) 1450 Poydras ST, STE 2136 New Orleans, LA 70112 www.lahap.org	1-504-568-7474 8 a.m.-5 p.m. local time, Monday-Friday
Maine | Maine AIDS Drug Assistance Program 40 State House Station Augusta, ME 04330-9758 http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/aids-drug-assist.shtml	1-207-287-3747 8 a.m.-5 p.m. local time, Monday-Friday
Maryland | Maryland AIDS Drug Assistance Program Client Services, 1223 W. Pratt ST Baltimore, MD 21223 https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx	1-410-767-6536 8:30 a.m.-4:30 p.m. local time, Monday-Friday
Massachusetts | AccessHealth MA ATTN: HDAP The Schrafft's City CTR, 529 Main ST, STE 301 Boston, MA 02129 https://accesshealthma.org/drug-assistance/hdap/	1-617-502-1700 8 a.m.-5 p.m. local time, Monday-Friday
Michigan | Link-Up Michigan Program c/o HIV Care Section c/o HIV Care SectionDivision of HIV/STI Programs, Client, and Partner Services Bureau of HIV and STI ProgramsMichigan Department of Health and Human ServicesP.O. Box 30727 Lansing, MI 48909 https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982_70541-456735–,00.html	1-888-826-6565 8 a.m.-5 p.m. local time, Monday-Friday
Minnesota | Minnesota HIV Programs Department of Human Services, P.O. Box 64972 St. Paul, MN 55164-0972 http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/contact-us/index.jsp	1-651-431-2398 9 a.m.-5 p.m. local time, Monday-Friday
Mississippi | Mississippi Department of Health, AIDS Drug Assistance Program 570 E Woodrow Wilson DR Jackson, MS 39215-1700 https://msdh.ms.gov/msdhsite/_static/14,13047,150.html	1-601-362-4879 8 a.m.-5 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Missouri | Missouri Bureau of HIV, STI and Hepatitis Department of Health and Senior Services, P.O. Box 570 Jefferson City, MO 65102-0570 https://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php	1-888-252-8045 8 a.m.-5 p.m. local time, Monday-Friday
Montana | State of Montana STI / HIV / HCV Prevention and Treatment Program DPHHS, Cogswell BLDG C-211, 1400 Broadway ST Helena, MT 59620-2951 https://dphhs.mt.gov/publichealth/hivstd/Treatment/mtryanwhiteprog	1-406-444-3565 8 a.m.-5 p.m. local time, Monday-Friday
Nebraska | NE Division of Public Health / Department of Health & Human Services Ryan White HIV/AIDS Program, P.O. Box 95026 Lincoln, NE 68509-5026 https://dhhs.ne.gov/Pages/HIV-Care.aspx	1-402-471-2101 8 a.m.-5 p.m. local time, Monday-Friday
Nevada | Nevada Medication Assistance Program 2290 S. Jones Blvd. Suite 110 Las Vegas, NV 89146 https://endhivnevada.org/adap-nmap/	1-702-486-0768 8 a.m.-5 p.m. local time, Monday-Friday
New Hampshire | New Hampshire ADAP Bureau of Infectious Disease Control 29 Hazen DR Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-adap	1-603-271-4496 8 a.m.-4:30 p.m. local time, Monday-Friday
New Jersey | New Jersey AIDS Drug Distribution Program (ADDP) P.O. Box 360 Trenton, NJ 08625-0360 http://www.state.nj.us/health/hivstdtb/hiv-aids/medications.shtml	1-877-613-4533 8 a.m.-4:30 p.m. local time, Monday-Friday
New Mexico | New Mexico Department of Health, AIDS Drug Assistance Program 1190 S Saint Francis DR, STE 1200 Santa Fe, NM 87505 http://nmhealth.org/about/phd/idb/hats/	1-505-827-2435 8 a.m.-5 p.m. local time, Monday-Friday
New York | New York AIDS Drug Assistance Program Uninsured Care Programs, Empire STA, P.O. Box 2052 Albany, NY 12220-0052	1-800-542-2437 9 a.m.-5 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information

http://www.health.ny.gov/diseases/aids/general/resources/adap/

North Carolina | North Carolina HIV Medication Assistance Program (HMAP) Communicable Disease BranchEpidemiology SectionDivision of Public HealthN.C. Dept of Health and Human Services1902 Mail Service Center Raleigh, NC 27699-1902 https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html	1-919-733-3419 8 a.m.-5 p.m. local time, Monday-Friday
North Dakota | North Dakota Ryan White Part B Program North Dakota Department of Health, Division of Disease Control 600 East Boulevard Ave Bismarck, ND 58506-5520 https://www.hhs.nd.gov/health/diseases-conditions-and-immunization/north-dakota-ryan-white-part-b-program	1-701-328-2310 8 a.m.-5 p.m. local time, Monday-Friday
Northern Mariana Islands | HIV/STI/Viral Hepatitis (VH) Prevention Program 1178 Hinemlu ST Garapan Saipan, MP 96950 https://phs.chcc.health/hiv-sti-program/	1-670-664-4050 7:30 a.m.-4:30 p.m. local time, Monday-Friday
Ohio | Ohio HIV Drug Assistance Program (OHDAP) Ohio Department of Health 246 N High ST Columbus, OH 43215 https://odh.ohio.gov/know-our-programs/ryan-white-part-b-hiv-client-services/aids-drug-assistance-program	1-800-777-4775 8 a.m.-5 p.m. local time, Monday-Friday
Oklahoma | Oklahoma Human Services 2400 N. Lincoln BLVD Oklahoma City, OK 73105 https://oklahoma.gov/okdhs/services/health/aids-coordination-and-information-services.html	1-405-522-5050 8 a.m.-5 p.m. local time, Monday-Friday
Oregon | Oregon CAREAssist 800 NE Oregon ST, STE 1105 Portland, OR 97232 http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx	1-971-673-0144 8 a.m.-5 p.m. local time, Monday-Friday
Pennsylvania | Pennsylvania Special Pharmaceutical Benefits Program Department of Health PO Box 8808 Harrisburg, PA 17120 https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx	1-800-922-9384 8 a.m.-4:30 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Puerto Rico | Departamento de SaludCarr. 8828, Km. 6.3 P.O. Box 70184 Río Piedras, PR 00936-8184 https://www.salud.pr.gov/CMS/99	1-787-765-2929 8 a.m.-4:30 p.m. local time, Monday-Friday
Rhode Island | Rhode Island AIDS Drug Assistance Program Executive Office of Health & Human Services 3 West RD Cranston, RI 02920 https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx	1-401-222-5960 8:30 a.m.-4:30 p.m. local time, Monday-Friday
South Carolina | South Carolina AIDS Drug Assistance Program (ADAP) DPH Headquarters State of South Carolina Health Campus 400 Otarre Parkway, Cayce, SC 29033 https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program	1-800-856-9954 8:30 a.m.-5 p.m. local time, Monday-Friday
South Dakota | Ryan White Part B CARE Program South Dakota Department of Health, 615 E 4th ST Pierre, SD 57501-1700 https://doh.sd.gov/topics/diseases-conditions/communicable-infectious-diseases/reportable-communicable-diseases/hivaids/ryan-white-part-b-program/	1-605-367-4795 8 a.m.-5 p.m. local time, Monday-Friday
Tennessee | Ryan White Part B Program Department of Health, 710 James Robertson PKWY Nashville, TN 37243 https://www.tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program/-tennessee-ryan-white-part-b-programs.html	1-615-253-3937 8 a.m.-4:30 p.m. local time, Monday-Friday
Texas | Texas HIV Medication Program ATTN: MSJA, MC 1873, P.O. Box 149347 Austin, TX 78714-9387 www.dshs.state.tx.us/hivstd/meds	1-800-255-1090 8 a.m.-5 p.m. local time, Monday-Friday
Utah | Ryan White HIV/AIDS Program 288 N 1460 W, P.O. Box 142104 Salt Lake City, UT 84114-2104 https://ryanwhite.hrsa.gov/about/ryan-white	1-301-443-1993 8 a.m.-5 p.m. local time, Monday-Friday
Vermont | VT Medication Assistance Program VT Department of Health280 State Drive Waterbury, VT 05671 http://healthvermont.gov/prevent/aids/aids_index.aspx	1-802-863-7200 7:45 a.m.-4:30 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information	
Virgin Islands of the U.S. | Community Health, Roy Lester Schneider Regional Medical Center 9048 Alton Adams Sr Dr St. Thomas, VI 00802 https://doh.vi.gov/programs/communicable-diseases	1-340-774-9000 8 a.m.-3:30 p.m. local time, Monday-Friday
Virginia | Virginia Medication Assistance Program (MAP) 109 Governor ST Richmond, VA 23219 https://www.vdh.virginia.gov/disease-prevention/vamap/	1-800-533-4148 8 a.m.-5 p.m. local time, Monday-Friday
Washington | Washington Early Intervention Program (EIP) Client Services, P.O. Box 47841 Olympia, WA 98504-7841 https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP	1-877-376-9316 8 a.m.-5 p.m. local time, Monday-Friday
West Virginia | West Virginia AIDS Drug Assistance Program (ADAP) 350 Capitol ST, RM 125 Charleston, WV 25301 https://bph.wv.gov/photo-call-out/epidemiology-and-prevention-services	1-304-558-5358 8 a.m.-4 p.m. local time, Monday-Friday
Wisconsin | Wisconsin AIDS Drug Assistance Program (ADAP) ATTN: HDAP201 E. Washington Ave.PO Box 2659 Madison, WI 53701-2659 https://www.dhs.wisconsin.gov/hiv/adap-consumer-client.htm	1-800-991-5532 8 a.m.-5 p.m. local time, Monday-Friday
Wyoming | Wyoming Department of Health Communicable Disease Unit 122 West 25th Street 3rd Floor West Cheyenne, WY 82002 https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/	1-307-777-7529 8 a.m.-5 p.m. local time, Monday-Friday

State Pharmaceutical Assistance Programs

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

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

- California - Office of AIDS Center for Infectious Diseases
- Colorado - Colorado Department of Health Care Policy & Financing
- Connecticut - Connecticut ADAP (CADAP)
- Delaware - Delaware Prescription Assistance Program

- District of Columbia - DC Pharmacy Benefits Program
- Guam - Guam Division of Senior Citizens (DSC)
- Idaho - Idaho AIDS Drug Assistance Program (IDADAP)
- Indiana - HoosierRx
- Louisiana - Louisiana Department of Health
- Maine - Office of MaineCare Services
- Maryland - Maryland Senior Prescription Drug Assistance Program (SPDAP)
- Massachusetts - Prescription Advantage Executive Office of Elder Affairs
- Missouri - MO HealthNet Division
- Montana - Montana Big Sky Rx
- Nevada - Nevada Care Connection
- New Jersey - New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD)
- New York - New York State EPIC Program
- Pennsylvania - Pennsylvania PACE
- Rhode Island - Rhode Island Pharmaceutical Assistance to Elders (RIPAE)
- Vermont - Green Mountain Care Prescription Assistance
- Virgin Islands of the U.S. - US Virgin Islands Pharmaceutical Assistance Program
- Wisconsin - Wisconsin SeniorCare Pharmaceutical Assistance Program

State Pharmaceutical Assistance Programs– Contact Information	
California | Office of AIDS Center for Infectious Diseases California Department of Public Health P.O. Box 997426, MS 7700 Sacramento, CA 95899-7426 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_hipp.aspx	1-844-421-7050 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Colorado | Colorado Department of Health Care Policy & Financing 303 E. 17th AVE STE 1100 Denver, CO 80203 https://www.colorado.gov/hcpf/contact-hcpf	1-800-221-3943 TTY 711 8 a.m.-4:30 p.m. local time, Monday-Friday
Connecticut | Connecticut ADAP (CADAP) State of CT Department of Public Health c/o Prime Therapeutics	1-800-424-3310 TTY 711

State Pharmaceutical Assistance Programs– Contact Information	
Management P.O. Box 13001 Albany, CT 12212-3001 https://ctdph.primetherapeutics.com/	8 a.m.-4 p.m. local time, Monday-Friday
Delaware | Delaware Prescription Assistance Program DHSS Herman Holloway Campus, Lewis Building 1901 N. DuPont Highway New Castle, DE 19720 https://dhss.delaware.gov/dmma/home/dpap/	1-844-245-9580 TTY 711 8 a.m. - 4:30 p.m. local time, Monday - Friday
District of Columbia | DC Pharmacy Benefits Program AIDS Drug Assistance Program (ADAP)2201 Shannon Place SE Washington, DC 20020 https://dchealth.dc.gov/node/137072	1-202-671-4815 TTY 711 8:30 a.m. - 5:30 p.m. local time, Monday - Friday
Guam | Guam Division of Senior Citizens (DSC) 130 University Drive, Suite 8University Castle Mall Mangilao, GU 96913 https://dphss.guam.gov/	1-671-735-7421 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Idaho | Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, FL 4 Boise, ID 83720-0036 https://healthandwelfare.idaho.gov/health-wellness/diseases-conditions/human-immunodeficiency-virus-hiv	1-208-985-3019 TTY 711 8 a.m.-5 p.m. local time, Monday-Friday
Indiana | HoosierRx 402 W Washington, Rm. 372 Indianapolis, IN 49204 https://www.in.gov/medicaid/members/194.htm	1-866-267-4679 TTY 711 8 a.m. - 4:30 p.m. local time, Monday - Friday
Louisiana | Louisiana Department of Health Medicare Savings Program. 628 N. 4th ST Baton Rouge, LA 70802 http://dhh.louisiana.gov/index.cfm/page/236	1-888-342-6207 TTY 1-800-220-5404 8 a.m. - 4:30 p.m. local time, Monday - Friday
Maine | Office of MaineCare Services 109 Capitol ST 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms	1-800-977-6740 TTY 711 7 a.m. - 6 p.m. local time, Monday - Friday
Maryland | Maryland Senior Prescription Drug Assistance Program (SPDAP) c/o International Software Systems Inc. PO Box 749 Greenbriar, MD 20768-0749 www.marylandspdap.com	1-800-551-5995 TTY 1-800-877-5156 8 a.m. - 5 p.m. local time, Monday - Friday

State Pharmaceutical Assistance Programs– Contact Information	
Massachusetts | Prescription Advantage Executive Office of Elder Affairs P.O. Box 15153 Worcester, MA 01615-0153 https://www.prescriptionadvantagema.org/	1-800-243-4636 TTY 1-877-610-0241 9 a.m. - 5 p.m. local time, Monday - Friday
Missouri | MO HealthNet Division Family Support Division PO Box 2700 Jefferson City, MO 65102 https://mydss.mo.gov/mhd	1-800-392-2161 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Montana | Montana Big Sky Rx P.O. Box 202915 Helena, MT 59620-2915 https://dphhs.mt.gov/SLTC/aging/BigSky	1-866-369-1233 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Nevada | Nevada Care Connection 4001 South Virginia St., Suite F Reno, NV 89702 https://www.nevadacareconnection.org/	1-877-861-1893 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
New Jersey | New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD) P.O. Box 715 Trenton, NJ 08625-0715 https://www.nj.gov/humanservices/doas/services/l-p/paad/	1-800-792-9745 TTY 711 8:30 a.m. - 4:30 p.m. local time, Monday - Friday
New York | New York State EPIC Program P.O. Box 15018 Albany, NY 12212-5018 http://www.health.ny.gov/health_care/epic/	1-800-332-3742 TTY 1-800-290-9138 8 a.m. - 5 p.m. local time, Monday - Friday
Pennsylvania | Pennsylvania PACE P.O. Box 8806 Harrisburg, PA 17105-8806 https://www.pa.gov/agencies/aging/aging-programs-and-services/pace-program.html	1-800-225-7223 TTY 711 8:30 a.m. - 5 p.m. local time, Monday - Friday
Rhode Island | Rhode Island Pharmaceutical Assistance to Elders (RIPAE) 25 Howard AVE, BLDG 57 Cranston, RI 02920 https://oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance	1-401-462-0560 TTY 1-401-462-0740 8:30 a.m. - 4 p.m. local time, Monday - Friday
Vermont | Green Mountain Care Prescription Assistance Department of Vermont Health Access, 280 State DR Waterbury,	1-800-250-8427 TTY 711

State Pharmaceutical Assistance Programs– Contact Information	
VT 05671-1020 https://dvha.vermont.gov/members/prescription-assistance	8 a.m. - 5 p.m. local time, Monday - Friday
Virgin Islands of the U.S. | US Virgin Islands Pharmaceutical Assistance Program 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 https://dhs.vi.gov/senior-citizen-affairs/	1-340-774-0930 TTY 711 8 a.m. - 5 p.m. local time, Monday - Friday
Wisconsin | Wisconsin SeniorCare Pharmaceutical Assistance Program Department of Health Services, 1 W Wilson ST, P.O. Box 6710 Madison, WI 53716-0710 http://www.dhs.wisconsin.gov/seniorcare	1-800-657-2038 TTY 711 8 a.m. - 6 p.m. local time, Monday - Friday

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 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this payment option, call Customer Service at 1-866-465-0572 (TTY users call 711) or visit Medicare.gov.

Medicare Prescription Payment Plan - Contact Information	
Call	1-866-465-0572 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday Customer Service 1-866-465-0572 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	UnitedHealthcare Customer Service Department

Medicare Prescription Payment Plan - Contact Information	
	P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	retiree.uhc.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 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. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number aren't 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 Customer Service 1-866-465-0572 (TTY users call 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. 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.

Chapter 3:
Using plan coverage for Part D drugs

Section 1 Basic rules for the 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, go to your **Medicare & You 2027** handbook.) Your Part D prescription drugs are covered under our plan.

The plan will generally cover your drugs as long as you follow these 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 (Go to Section 2 **or you can fill your prescription through the plan's mail-order service**)
- Your drug must be on the 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's either approved by the Food and Drug Administration (FDA) or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from the plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

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

In most cases, your prescriptions are covered **only** if they're filled at the plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your **Pharmacy Directory**, visit our website (retiree.uhc.com), and/or call Customer Service at 1-866-465-0572 (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, call Customer Service at 1-866-465-0572 (TTY users call 711) or use the **Pharmacy Directory**. You can also find information on our website at retiree.uhc.com.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Customer Service at 1-866-465-0572 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your **Pharmacy Directory** (retiree.uhc.com) or call Customer Service at 1-866-465-0572 (TTY users call 711).

Section 2.2 Our plan's mail-order service

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

To get order forms and information about filling your prescriptions by mail you may contact our preferred mail service pharmacy, Optum® Home Delivery Pharmacy at 1-888-279-1828, (TTY)711, 24 hours a day, 7 days a week. Please reference your **Pharmacy Directory** to find the mail service pharmacies in our network. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will be delivered to you in no more than 10 business days. Optum Home Delivery Pharmacy and Optum Rx affiliates may not be available in all areas. However, sometimes your mail-order may be delayed. If your mail-order is delayed, please follow these steps:

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

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

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

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

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, contact us by phone or mail.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It'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, contact us by phone or mail.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you are in need of more medication, and you can cancel

scheduled refills if you have enough medication or your medication has changed. If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 10 days before your current prescription will run out. This will ensure your order is shipped to you in time.

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

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

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

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. There may be other pharmacies in our network. **Optum Home Delivery Pharmacy and Optum Rx affiliates may not be available in all areas.**

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

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers 2 ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your **Pharmacy Directory** (retiree.uhc.com) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at 1-866-465-0572 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

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

Generally, we cover drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. Check first with Customer Service at 1-866-465-0572 (TTY users call 711) to see if there's a network pharmacy nearby.

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

- **Prescriptions for a medical emergency**
  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are

related to care for a medical emergency or urgently needed care, are included in our Drug List without restrictions, and are not excluded from Medicare Part D coverage.

- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy that provides 24-hour service is not within reasonable driving distance.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.
- Any prescriptions filled outside of the United States are not covered.

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

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

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

The drugs on this list are selected by the 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 use of the drug is for a medically accepted indication. A medically accepted indication is a use of the drug that is **either**:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

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

A brand name drug is a prescription drug 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.

Drugs that aren't on the Drug List

The 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 4 "cost-sharing tiers" for drugs on the Drug List

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

Tier 1 – Preferred Generic - All covered generic drugs

Tier 2 – Preferred Brand - Many common brand name drugs, called preferred brands

Tier 3 – Non-Preferred Drug - Non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in tier 3.

Tier 4 – Specialty Tier - Unique and/or very high-cost brand drugs

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4.

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:

1. Visit the plan's website (retiree.uhc.com) for the most current information.
2. Call Customer Service at 1-866-465-0572 (TTY users call 711) to find out if a particular drug is on the plan's Drug List or ask for a copy of the list.
3. Use the plan's "Real-Time Benefit Tool" (retiree.uhc.com) to search for drugs on the Drug List to get an estimate of what you'll pay and if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Service at 1-866-465-0572 (TTY users call 711).

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, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost-sharing may apply to the different versions of the drug (for example, 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 Customer Service at 1-866-465-0572 (TTY users call 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).

What is a compounded drug?

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

Does my Part D plan cover compounded drugs?

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

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

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

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

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

A compounded drug that is Part D eligible may require an approved coverage determination to be covered by your plan. You will pay the non-preferred drug copayment or coinsurance amount for compounded drugs that are approved. No further tier cost share reduction is allowed or available.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan based on specific criteria before we 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 the plan. Our plan's prior authorization criteria can be obtained by calling Customer Service at 1-866-465-0572 (TTY users call 711) or on our website retiree.uhc.com.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A doesn't work for you, the 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 Customer Service at 1-866-465-0572 (TTY users call 711) or on our website retiree.uhc.com.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it'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 (formulary) or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage
- The drug is covered, but 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 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, the 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 the 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 the plan.
- **If you were in the plan last year**, we'll cover a temporary supply of your drug during the first 90 days of the plan year.
- This temporary supply will be for at least a 30-day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to at least a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For members who've been in the plan for more than 90 days and live in a long-term care facility and need a supply right away:**
  We'll cover at least a 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

- **For current members with level of care changes:**
  There may be unplanned transitions such as hospital discharges (including psychiatric hospitals) or level of care changes (i.e., changing long-term care facilities, exiting and entering a long-term care facility, ending Part A coverage within a skilled nursing facility, or ending hospice coverage and reverting to Medicare coverage) that can occur anytime. If you're prescribed a drug that's not on our Drug List or your ability to get your drugs is restricted in some way, you're required to use the plan's exception process. For most drugs, you may request a one-time temporary supply of at least 30 days to allow you time to discuss alternative treatment with your doctor or to request a Drug List (formulary) exception. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 30-day supply.

For questions about a temporary supply, call Customer Service at 1-866-465-0572 (TTY users call 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 your 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 the plan may work just as well for you. Call Customer Service at 1-866-465-0572 (TTY users call 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 the 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 the plan to cover a drug even though it's not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you'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 to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Service at 1-866-465-0572 (TTY users call 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 the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

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.

Drugs in our Tier 4 Specialty Tier aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

Section 6 Our Drug List can change during the year

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

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

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our website regularly. 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 30 days before we make the change or tell you about the change and cover at least a 30-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 are taking. For example, we might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-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 change 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 won't 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 or its territories
- Our plan can't cover **off-label** use of a drug when the use isn't 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 aren't covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)

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

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

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 the plan's Drug List or call Customer Service at 1-866-465-0572 (TTY users call 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 your prescription, provide your UnitedHealthcare member ID information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill the plan for **our** share of your drug cost. You need to pay the pharmacy **your** share of the cost when you pick up your prescription.

If you don't have your plan membership information with you, you or the pharmacy can call the 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 the plan for reimbursement.

Section 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility

If you're 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 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 an 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** (retiree.uhc.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 Customer Service at 1-866-465-0572 (TTY users call 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 getting a temporary or emergency supply.

Section 9.3 If you are taking drugs covered by Original Medicare

Your enrollment in UnitedHealthcare® MedicareRx for Groups (PDP) doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you'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 UnitedHealthcare® MedicareRx for Groups (PDP) 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 UnitedHealthcare® MedicareRx for Groups (PDP) for the drug.

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

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

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

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

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**. 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 drug coverage for the next plan year is "creditable."

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

Keep any notices about creditable coverage, because you may need these notices later to show that you 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 get 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 getting 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 for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- 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'll 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 we continue to deny any part of your request about 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, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

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

We have programs that can help our members with complex health needs. One program is called a Medication Therapy Management (MTM) program. These programs are voluntary and free. A team of pharmacists and doctors developed the programs for us to help make sure 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 the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care 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 these programs, contact Customer Service at 1-866-465-0572 (TTY users call 711).

Chapter 4:

What you pay for Part D drugs

Section 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service at 1-866-465-0572 (TTY users call 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.

Your plan sponsor offers additional prescription drug coverage. Please see your Additional Drug Coverage list for more information. 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.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (retiree.uhc.com), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Customer Service at 1-866-465-0572 (TTY users call 711).

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 covered for Part D drugs that you may be asked to pay:

- **"Deductible"** is the amount you pay for drugs before our plan starts to pay our share.
- **"Copayment"** is a fixed amount you pay each time you fill a prescription.
- **"Coinsurance"** is a percentage of the total cost you pay each time you fill a prescription.

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 any of the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare 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 $2,400 in out-of-pocket costs within the plan year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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:

- 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
- Prescription drugs and vaccines 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 your out-of-pocket costs for drugs, you're required to tell our plan by calling Customer Service at 1-866-465-0572 (TTY users call 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.

- **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 UnitedHealthcare® MedicareRx for Groups (PDP) members

There are 3 **drug payment stages** for your drug coverage under UnitedHealthcare® MedicareRx for Groups (PDP). 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 the 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**
- **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 your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you 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 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 the total drug 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.** 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.

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here's how you can help us keep your information correct and up to date:

- **Show your UnitedHealthcare member ID 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 buy covered drugs at out-of-network pharmacies or pay the 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 report we send you.** When you get the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Customer Service at 1-866-465-0572 (TTY users call 711). You can also view your EOB on our website at retiree.uhc.com. Be sure to keep these reports.

Section 4 There is no deductible for the plan

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

Section 5 The Initial Coverage Stage

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

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

Our plan has 4 cost-sharing tiers

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

Tier 1 – Preferred Generic - All covered generic drugs

Tier 2 – Preferred Brand - Many common brand name drugs, called preferred brands

Tier 3 – Non-Preferred Drug - Non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in tier 3.

Tier 4 – Specialty Tier - Unique and/or very high-cost brand drugs

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

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that isn't in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 3, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy

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

Section 5.2 Your costs for a one-month supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

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

The table below shows what you pay when you get a 30-day supply and a long-term 90 -day supply of a drug.

Your costs for a covered Part D drug

Tier	**Standard retail cost-sharing (in-network)** (30-day supply)	**Mail-order cost-sharing** (90-day supply)	**Out-of-network cost-sharing** (Coverage is limited to certain situations; go to Chapter 3 for details.) (30-day supply)
Cost-Sharing Tier 1 Preferred Generic	20% coinsurance, with a $75 maximum	20% coinsurance, with a $150 maximum	20% coinsurance, with a $75 maximum*
Cost-Sharing Tier 2 Preferred Brand[1]	20% coinsurance, with a $75 maximum	20% coinsurance, with a $150 maximum	20% coinsurance, with a $75 maximum*
Cost-Sharing Tier 3 Non-preferred Drug[1]	20% coinsurance, with a $75 maximum	20% coinsurance, with a $150 maximum	20% coinsurance, with a $75 maximum*
Cost-Sharing Tier 4 Specialty Tier[1]	20% coinsurance, with a $75 maximum	20% coinsurance, with a $150 maximum	20% coinsurance, with a $75 **maximum***

[1] Subject to Medicare guidance, coinsurance may not apply to Part D insulin products. You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan.

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

If you obtain less than a 90-day supply from the mail-order pharmacy for any reason, the in-network standard retail cost-sharing amount applies.

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

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

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

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 You stay in the Initial Coverage Stage until your out-of-pocket costs (what you and others on your behalf pay) for the year reach $2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,400.** You then move to the Catastrophic Coverage Stage.

The Part D EOB you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf for your drugs during the year. Not all members will reach the $2,400 limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

Section 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,400 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, the plan pays the full cost for your Medicare-covered Part D drugs. You pay nothing.
- For additional drugs covered under our enhanced benefit, you will pay the Initial Coverage cost shares listed in Section 5.2.

Section 7 Additional benefits information

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

1. Medications will not be covered if prescribed by physicians or other providers who are excluded or precluded from the Medicare program participation.
2. Costs for drugs that are not covered under Part D do not count toward your Out-of-Pocket costs.

Section 8 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 Customer Service at 1-866-465-0572, 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 3 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 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 the 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 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 a 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 coinsurance or 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 Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay 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 coinsurance or 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 nothing for the vaccine itself.
- For other 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 coinsurance or 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 us to pay our 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 to 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 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 2.4 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 don't have our UnitedHealthcare ID card with you**

   If you don't have our UnitedHealthcare ID 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 our 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 to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

4. If you're retroactively enrolled in our plan

- Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

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

- When you send us a request for payment, we'll review your request and decide whether the drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make 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(s) documenting the payment you have made. It's a good idea to make a copy of your receipt(s) for your records.

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

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

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

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 a 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.
- 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 rights to appeal that 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 have 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're 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.

Chapter 6:
Your rights and responsibilities

Section 1 Our plan must honor your rights and cultural sensitivities

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

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

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service number at 1-866-465-0572 for additional information (TTY users should call 711).

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Se nos exige que le proporcionemos la información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener más información de nuestra parte de una forma que le resulte conveniente, llame al número de Servicio al Cliente al 1-866-465-0572 (los usuarios de TTY deben llamar al 711).

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, call to file a grievance with Customer Service (phone numbers are printed on the cover of this booklet). 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 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to 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 you aren't getting your Part D drugs within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we're required to get written permission from you or someone you've 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 that information that uniquely identifies you not be shared.

How is your health information shared and protected?

Sharing with your providers

We automatically share your health information with your network providers so they can work together on your care. This helps them coordinate your treatment, make faster treatment decisions, and improve your overall health experience.

We keep your health information safe with strong privacy and security protections. Only providers who have treated you and are part of our network can view your information.

And you're always in control – if you don't want to share your information, you can opt out at any time. And if you change your mind later, you can opt back in. Even if you choose to opt out, your provider may still access some information as allowed by law to make sure you get the right care.

Sharing with other health plans

If you have more than one health plan at the same time or change plans later, you can choose to allow us to request and share your health information with those plans. This helps keep your medical records complete and together in one place. It also helps with transitions in care and gives your health plans the information they need to best support you.

Your health information isn't shared automatically – you must give us permission to do so. You can change your mind at any time to start or stop sharing your health information. We'll only share your information with health plans you're enrolled in, and we'll be using privacy and security protections.

How to manage your sharing preferences

You can start or stop sharing your health information with your providers and other health plans whenever you like. To update your preferences, go to **retiree.uhc.com**:

1. Sign in to your account
2. In the **My personal support network** section at the bottom left of the page, select **Manage access**
3. Under **Data sharing**, choose who you want to share your health information with

Or call us toll-free at **1-866-465-0572**, TTY **711**, 8 a.m.-8 p.m. local time, Monday-Friday for help updating your preferences.

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 by 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, call Customer Service at **1-866-465-0572** (TTY users call 711).

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

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

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

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

How We Collect, Use, and Disclose Information

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

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

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

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.

- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- **For Health Care Operations** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors,** if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes;** however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders,** we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.

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

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

    1. Alcohol and Substance Use Disorder
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases

5. Genetic Information
6. HIV/AIDS
7. Mental Health
8. Minors' Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

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

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For information on how to revoke your authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

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

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health

information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, **please call the toll-free member phone number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-465-0572 (TTY/RTT 711).**
- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at the following address:

  UnitedHealthcare

  Customer Service - Privacy Unit

  PO Box 740815

  Atlanta, GA 30374-0815

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

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

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

Financial Information Privacy Notice

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

Effective January 1, 2024

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

Information We Collect

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

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

Disclosure of Information

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

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

Confidentiality and Security

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

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-465-0572 (TTY 711).**

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

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

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

If you want any of the following kinds of information, call Customer Service at 1-866-465-0572 (TTY users call 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 the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation 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 health 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 health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means **if you want to**, you can:

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

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

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

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service for assistance in locating an advanced directive form.
- **Fill 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 to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you'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 appropriate state-specific agency, for example, your State Department of Health.

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

If you have any problems, 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 aren't 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 users call 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:

- Call Customer Service at **1-866-465-0572 (TTY users call 711)**
- **Call your local SHIP at 1-877-801-0044**.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

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

Get more information about your rights from these places:

- Call Customer Service at **1-866-465-0572 (TTY users call 711)**

- For information on the quality program for your specific health plan, call Customer Service. You can also access this information online at uhc.com/medicare/resources.html. Open the Additional Medicare information and forms section and select Find information. Then select Other resources and plan information and then Commitment to quality.
- **Call your local SHIP at 1-877-801-0044**.
- Contact **Medicare**.
  - –Visit medicare.gov to read the publication **Medicare Rights & Protections** (available at: medicare.gov/publications/11534-medicare-rights-and-protections.pdf)
  - –Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

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 Customer Service at **1-866-465-0572** (TTY users call 711).

- **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 give details about Part D drug coverage.
- **If you have any other prescription drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you're enrolled in our plan.** Show your UnitedHealthcare member ID 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're responsible for these payments:
  - –Your prescription drug coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium, if applicable. If you have a plan premium, you must pay your plan premiums to continue being a member of our plan.
  - –For most of your drugs covered by our plan, you must pay your share of the cost when you get the drug.

- If you're required to pay a late enrollment penalty, you must pay the penalty to stay a member of our plan.
- If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move outside our plan service area, you can't 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.
- 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 and 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 customer service at **1-866-465-0572** (TTY users call **711**) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organization 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. For more information or to contact a SHIP counselor, visit https://www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html or call 1-877-801-0044, TTY 1-800-848-0299.

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- 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, customer service 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 benefits

If you want to know if we'll cover a specific drug 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.

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.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Making an appeal

If we make a coverage decision, whether before or after you get a service, 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 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 Customer Service at 1-866-465-0572. (TTY users call 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 make an appeal.

- If you want a friend, relative, or another person to be your representative, call Customer Service at 1-866-465-0572 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available 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 from a representative without the form, but we can't begin or 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 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 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.

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 an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

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

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

Section 5.2 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 are 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 to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 3. 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**. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost sharing tier.** Every drug on our Drug List is in one of 4 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 our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost sharing tier than your drug, you can ask us to cover your drug at the cost sharing amount that applies to the alternative drug(s).

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

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

– You can't ask us to change the cost sharing tier for any drug in Tier 4 Specialty Tier.

– 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 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 generally **won't** 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 Step-by-step: How to ask for a coverage decision, including an exception

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



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

Standard coverage decisions are made within **72** hours after we 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 yet**. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could **cause serious harm to your health or hurt your ability to regain function.**
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll 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, which is available on our website (retiree.uhc.com). Chapter 2 has contact information. 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 are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the 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'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 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 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 to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the 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 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. We'll let you know in writing if your request has been sent to the 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 make 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.
- **For fast appeals, either submit your appeal in writing or call us at 1-866-465-0572.** 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 (retiree.uhc.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.



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

- When we review your appeal, we take another careful look at all 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 to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the 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 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 you can 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. We'll let you know in writing if your request has been sent to the 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 you can 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 to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the 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 make another appeal.

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

Section 5.6 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 make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent 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 let you know in writing if your request has been sent to the independent review organization.
- 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.**
- 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 explains 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 and 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 were 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 get 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 drug coverage 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 drug coverage 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 drug coverage 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, customer service, or other concerns

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

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

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you got?
Respecting your privacy	• Did someone not respect your right to privacy or shared confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Service 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 Customer Service at 1-866-465-0572, (TTY users call 711) is usually the first step**. If there's anything else you need to do, Customer Service 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.
- We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.
- If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address/fax numbers for filing complaints is located in Chapter 2, Section 1 under "How to contact us when you are making a complaint about your Part D prescription drugs."
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.



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

- **If possible, we'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 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'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 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 health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 7.4 You can also tell Medicare about your complaint

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

Chapter 8:

Ending membership in our plan

Section 1 Ending your membership in our plan

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

- You might leave our plan because you decide you **want** to leave. Section 2 give information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we're required to end your membership. Section 4 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.

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

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

Section 2.1 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- Call your plan sponsor
- **Call Customer Service at 1-866-465-0572 (TTY users call 711).**
- Find the information in the **Medicare & You** 2027 handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

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

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

Section 4 We must end our plan membership in certain situations

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

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

- We are notified that you no longer meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).
- Your former employer, union group or trust administrator's (plan sponsor's) contract with us is terminated.
- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you're away from our service area for more than 12 months.
  - If you move or take a long trip, call Customer Service at 1-866-465-0572 (TTY users call 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 national, or an eligible noncitizen.
- 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're 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's 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 UnitedHealthcare 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.

- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Customer Service at 1-866-465-0572 (TTY users call 711).

Section 4.2 We can't ask you to leave our plan for any health-related reason

Our plan isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

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

Chapter 9:
Legal notices

Section 1 Notice about governing law

The principal law that applies to this **Evidence of Coverage** document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (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 non-discrimination

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, 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, call us at Customer Service 1-866-465-0572 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare prescription drug plan sponsor, will exercise the same rights of

recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Section 4 Third party liability and subrogation

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

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

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

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

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

The following persons and entities are considered third parties:

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

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

The following is agreed upon between you and us:

- You will cooperate with us in protecting our legal rights to subrogation and reimbursement; and you acknowledge that our rights under this Section will be considered as the first priority claim against any Third Parties, to be paid before any of your other claims are paid. Specifically, but without limitation, you agree to: (i) provide any relevant information we may request; (ii) sign and deliver such documents as we or our agents may reasonably request to secure the subrogation claim; (iii) respond to requests for information about any accidents or injuries; (iv) make court appearances; (v) obtain the consent of the plan or our agents before releasing any party from liability for or payment of medical expenses. We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf; and (vi) you may not accept any settlement that does not fully reimburse us without its written approval.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- You will do nothing to prejudice our rights under this provision, either before or after the need for drugs under this EOC. We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit on our own behalf as your subrogee. Your failure to cooperate in this manner shall be deemed a breach of this contract and may result in the institution of legal action against you.
- We will not use the rights enumerated throughout this Section to affect or impair any parental financial obligations, such as child support, associated with Pregnancy.
- No court costs or attorneys fees may be deducted from our recovery without our express written consent; and no so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right. We are not required to participate in or pay court costs or attorneys fees to any attorney or other representative or agent hired by you to pursue a claim relating to your Sickness or Injury.
- We may collect, at our opinion, amounts from proceeds of any Third Party settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether you or your legal representative have been made whole. You will hold any proceeds of such a Third Party settlement or judgment in a constructive trust for our benefit under these subrogation provisions. We will be entitled to recover from you reasonable attorney fees incurred in collecting proceeds held by you.
- The plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages.
- The plan’s rights to recovery will not be reduced due to your own negligence.

- We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- We have the responsibility for administering the terms and conditions of the subrogation and reimbursement rights and have such powers and duties as are necessary to discharge these duties and functions, including the exercise of discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Section 5 Member liability

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

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

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

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

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be

expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your drugs exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.**

Section 7 Acts beyond our control

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

Section 8 Contracting network pharmacies

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

Section 9 Disclosure

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

Section 10 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered drugs under this Evidence

of Coverage and the Schedule of Benefits or be used in defense of a legal action unless it is contained in a written application.

Section 11 Information upon request

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

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

Section 12 Commitment of Coverage Decisions

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

Chapter 10:

Definitions

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's 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's 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 $2,400 for Medicare-covered Part D drugs during the covered year. During this payment stage, you pay nothing for your Medicare-covered Part D drugs.

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

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

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

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

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

Cost-sharing – Cost-sharing refers to the amounts that a member has to pay when drugs are received. (This is in addition to our plan's monthly premium.) Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before drugs are covered; 2) any fixed copayment amount that a plan requires when a specific drug is received; or 3) any coinsurance amount, a percentage of the total amount paid for a drug that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 4 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 our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't 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 the prescription drugs covered by our plan.

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

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

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you'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.

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

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

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

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

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

Dually Eligible Individuals – A person who is eligible for Medicare and Medicaid coverage.

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that 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's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan or pharmacies, including a complaint concerning the quality of your care. This 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 after you pay your deductible (if you have one) and 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 about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

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

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

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our 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.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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 age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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

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

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This

term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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).

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

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

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) **–** Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 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 aren't 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 received is also referred to as the member's "out-of-pocket" cost requirement.

Out-of-Pocket Threshold – The maximum amount you and others on your behalf pay out-of-pocket for Part D drugs.

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

Part C – Go to **Medicare Advantage (MA) Plan.**

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

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

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

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

Prior Authorization – Approval in advance to get certain drugs based on specific criteria. Covered drugs that need prior authorization are marked in the formulary.

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

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

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.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular prescription drug plan. Our plan must 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 drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'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 age 65 and older. SSI benefits aren't the same as Social Security benefits.

UnitedHealthcare® MedicareRx for Groups (PDP) Customer Service:

Download the **UnitedHealthcare app**

Visit **retiree.uhc.com**

Call **1-866-465-0572**
Calls to this number are free.
8 a.m.-8 p.m. local time, Monday-Friday.
Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**
Calls to this number are free.
8 a.m.-8 p.m. local time, Monday-Friday.

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

State Health Insurance Assistance Program

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

You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

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