

January 1 – December 31, 2026

Evidence of Coverage for 2026:

University of California High Option Supplement to Medicare

Your Medicare Drug Coverage as a Member of Navitus MedicareRx Prescription Drug Plan (PDP)

This document gives the details of your Medicare drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.** This document explains your benefits and rights. Use this document to understand:

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

For questions about this document, please contact Customer Care at 1-833-837-4309 (TTY users call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. This call is free.

This plan, Navitus MedicareRx (PDP), offered by Dean Health Insurance, Inc., is a prescription drug plan with a Medicare contract. When this Evidence of Coverage says “we,” “us,” “plan,” “our plan” or “our,” it means Navitus MedicareRx.

The University of California has implemented an Employer Group Waiver Plan (EGWP) for Medicare-eligible retirees. This plan is administered by Navitus Health Solutions. This means that Medicare-eligible retirees and/or dependents are enrolled in a Group Medicare Part D Plan. Your employer group plan also includes supplemental coverage that wraps around the benefits provided by Medicare Part D. Your employer group plan also includes supplemental coverage that wraps around the benefits provided by Medicare Part D. For plan premium or enrollment questions, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific).

This document is available for free in Spanish. This document is also available in alternate formats (e.g., braille, large print, audio) as applicable.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

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

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Navitus MedicareRx

Section 1.1 You're enrolled in Navitus MedicareRx, which is a Medicare Drug Plan

You are covered by Original Medicare and your UC High Option Supplement to Medicare plan for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, Navitus MedicareRx (PDP). However, cost sharing and provider access in this plan differ from Original Medicare.

Navitus MedicareRx (PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company. In addition, your retiree drug coverage includes non-Medicare supplemental drug coverage provided by your Navitus MedicareRx benefits.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Navitus MedicareRx 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 Navitus MedicareRx between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Navitus MedicareRx after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Navitus MedicareRx 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 have Medicare Part A and Medicare 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 lawfully present in the United States.
- You continue to be eligible under any additional criteria that have been determined by your employer group.

Section 2.2 Plan service area for Navitus MedicareRx

Navitus MedicareRx is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described as all 50 states, Puerto Rico, U.S. Virgin Islands, and Guam.

If you move out of our plan's service area, you can't stay a member of this plan. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location. If you plan to move out of the service area, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific).

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 lawful presence

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

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

While you are a member of our plan, you must use your membership card for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample membership card:



Carry your card with you at all times and remember to show your card when you get covered drugs. If our plan membership card is damaged, lost, or stolen, call Customer Care at Customer care number: 1-833-837-4309 (TTY users call 711) 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* lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 3, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.⁸⁹

To request a *Pharmacy Directory*, contact Customer Care at 1-833-837-4309 (TTY users call 711). You can also find this information on the member portal, memberportal.navitus.com or ucal.us/medicaresupplement. Also, there is a pharmacy search tool on the member portal, click on *Pharmacy Search* on the top navigation bar.

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

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

We will provide you with a copy of the Drug List. The Drug List includes information for the covered drugs that are most used by our members. However, we cover additional drugs that are not included in the Drug List. If one of your drugs is not listed in the Drug List, visit the member portal, or contact Customer Care to find out if we cover it. To get the most complete and current

information about which drugs are covered, you can visit the member portal, <https://memberportal.navitus.com> or ucal.us/medicaresupplement or call Customer Care.

SECTION 4 Your monthly costs for Navitus MedicareRx

	Your Costs in 2026
	Your Costs in 2026
Monthly plan premium* Your coverage is provided through your employer group. (Go to Section 4.1 for details)	For information concerning the actual premiums you will pay, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific).
Part D drug coverage deductible (Go to Chapter 4 Section 4 for details)	\$0
Part D drug coverage (Go to Chapter 4 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	During the Initial Coverage Stage: Cost Sharing Levels Retail Network (Up to 30 days) Tier \$0: Select generics (not all dosages of these drugs are covered at the Select generics cost share) - \$0 copayment Tier 1: Preferred generics and some lower cost brand products - \$15 copayment Tier 2: Preferred Brand products and some high cost non-preferred generics - \$35 copayment Tier 3: Non-preferred drugs (could include some high cost non-preferred generics) - \$50 copayment

Your Costs in 2026

Tier 4: Specialty products - \$35 copayment

Catastrophic Coverage Stage:

During this payment stage, you pay nothing for your covered Part D drugs.

You may have cost sharing for drugs that are covered under our enhanced benefit.

Your costs may include the following:

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

Section 4.1 Plan Premium

Your coverage with Navitus MedicareRx is provided through a contract with your former employer or union. **For information concerning the actual premiums you will pay, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific).**

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. The Extra Help program helps people with limited resources pay for their drugs.

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 may have 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 have questions whether you should have received this insert, contact Customer Care at 1- 833-837-4309 (TTY users call 711) and ask about the *LIS Rider*.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website at (<https://www.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

Many members are required to pay other Medicare premiums

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

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not 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 prescription 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 will have to pay this penalty for as long as you have Part D coverage. You will receive further instructions for paying your late enrollment penalty in a separate notice.

The Part D late enrollment penalty is added to your premium. When you first enroll in Navitus MedicareRx (PDP), we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could be disenrolled from the plan.

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

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

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2025, this average premium amount is \$36.78. This amount may change for 2026.

- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14% times \$36.78, which equals \$5.14. This rounds to \$5.10. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

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

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from two 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](https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans).

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

If you are participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

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

SECTION 5 More information about the Part D monthly premium

Section 5.1 How to pay the Part D plan premium

Please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific) to find out what your plan premium is and how to pay for it. Your benefits administrator can discuss different payment options with you, if applicable.

If you pay a Part D monthly plan premium and have trouble paying your plan premium

If you have trouble paying your *premium* on time, contact your employer group.

If your membership ends because you did not pay your plan premium you'll have health coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

If you think we or your employer group has wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium and/or your Part D late enrollment penalty, if owed (within our grace period), you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 7 of this document tells how to make a complaint or you can call us at 1-833-837-4309, 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Your Part D monthly plan premium is set by your employer group and won't change during the coverage year

CMS does not allow a change to the amount of your monthly Part D premium plan during the year. If the monthly plan premium changes for the next coverage year, your employer group will communicate this information to you.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of our 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.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

Supplemental Coverage: For questions regarding changes to your supplemental (wrap) coverage premium, please contact the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.). Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific). Remember: Your total group health insurance premium includes the cost of your prescription drug benefits, including this plan.

SECTION 6 Keep our 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 Care at 1- 833-837-4309 (TTY only, 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 Care at 1- 833-837-4309 (TTY only, 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 Navitus MedicareRx contacts

How to contact our plan's Customer Care

For help with claims, billing, or member card questions, call or write to Navitus MedicareRx Customer Care. We'll be happy to help you.

Customer Care – Contact Information

Call	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.
Write	Navitus MedicareRx Customer Care P.O. Box 1039 Appleton, WI 54912-1039
Website	memberportal.navitus.com or ucal.us/medicaresupplement

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 and Appeals for Medical Care or Part D drugs – Contact Information

Call	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.
Write	Navitus MedicareRx Prior Authorization P.O. Box 1039 Appleton, WI 54912-1039
Website	memberportal.navitus.com or ucal.us/medicaresupplement

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 does not involve coverage or payment disputes. For more information on making a complaint about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Complaints – Contact Information

Call	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.

Write	Navitus MedicareRx Grievances & Appeals P.O. Box 1039 Appleton, WI 54912-1039
Medicare website	You can submit a complaint about Navitus MedicareRx directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

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

If you got a bill or paid for drugs (like a pharmacy bill) you think we should pay for, you may need to ask our plan for reimbursement or to pay the pharmacy bill. Go to Chapter 5 (*Asking us to pay our share of the costs for covered drugs*) 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 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Payment Requests – Contact Information

Call	1-833-837-4309 Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Pharmacies can also reach Navitus Customer Care 24 hours a day, 7 days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. We are available 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day. Customer Care also has free language interpreter services available for non-English speakers.
Fax	1-855-668-8550
Write	Navitus MedicareRx Manual Claims P.O. Box 1039 Appleton, WI 54912-1039
Website	memberportal.navitus.com or ucal.us/medicaresupplement

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. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about Navitus MedicareRx.

To submit a complaint to Medicare, go to [Medicare.gov/MedicareComplaintForm/home.aspx](https://www.medicare.gov/MedicareComplaintForm/home.aspx). Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

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. Please refer to **Exhibit A** for the name and contact information of the specific SHIP in your state.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

SECTION 4 Quality Improvement Organizations (QIO)

A designated Quality Improvement Organization serves people with Medicare in each state. Please refer to **Exhibit B** for the name and contact information of the specific Quality Improvement Organization in your area.

The QIO 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 QIO is an independent organization. It is not connected with our plan.

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

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 its programs, please refer to **Exhibit C** for the name and contact information of your state specific Medicaid program.

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website ([Medicare.gov/basics/costs/help/drug-costs](https://www.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 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 anytime. 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.

- If you do not have evidence of “Extra Help,” notify the pharmacy when you pick up your prescription. The pharmacy will contact us, and we will work with Medicare to get this evidence for you.
- When we get the evidence showing the right copayment level, we’ll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we’ll pay you back either by check or a future copayment credit. If the pharmacy didn’t collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Care at 1-833-837-4309 (TTY only, call 711) if you have questions.

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

To find out more about the State Pharmaceutical Assistance Program (SPAP), please refer to **Exhibit D** for the name and contact information of your state specific SPAP.

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 ADAP in your 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, 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, refer to **Exhibit E** for the name and contact information of your state specific ADAP.

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.

To find out more about the State Pharmaceutical Assistance Program (SPAP), please refer to **Exhibit D** for the name and contact information of your state specific SPAP.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Customer Care at 1-833-837-4309 (TTY only, call 711) or visit [Medicare.gov](https://www.Medicare.gov).

Medicare Prescription Payment Plan – Contact Information

Call	1-833-696-2087 Calls to this number are free. Hours of Operation: October 1 – March 31 from 8 am to 8 pm within your time zone, 7 days a week April 1 – September 30 from 8 am to 8 pm within your time zone, Monday through Friday (voicemails monitored on weekends) Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free October 1 – March 31 from 7am to 10pm Central Time, 7 days a week April 1 – September 30 from 7am to 10pm Central Time, Monday through Friday (voicemails monitored on weekends)
Fax	440-557-6525
Write	Navitus MedicareRx (PDP) Mailstop: 1002 MPPP Election Dept. 13900 N. Harvey Ave

	Edmond, OK 73013
Website	Medicarerx.navitus.com/m3p

SECTION 8 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information

Call	1-877-772-5772 Calls to this number are free. 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 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, you may call the UC Retirement Administration Service Center (RASC) at 1-800-888-8267 (in U.S.) or 1-510-987-0200 (from outside the U.S.), so they will have your most up-to-date contact information on file. Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m. (Pacific). or Customer Care if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. Please contact Customer Care at 1-833-837-4309. (TTY users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day. You may also call 1-800-MEDICARE (1-800-633-4227; TTY number is 1-877-486-2048) with questions related to your Medicare coverage under this 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**. 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 our plan's Part D drug coverage

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

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, go to your *Medicare & You 2026* handbook.) Your Part D prescription drugs are covered under our plan.

Our 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).
- Your drug must be on our plan's Drug List (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain references. (Go to Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

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

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

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website memberportal.navitus.com or ucal.us/medicaresupplement and/or call Navitus MedicareRx Customer Care at 1-833-837-4309 (TTY users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

You may go to any of our network pharmacies. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, you can get help from Customer Care or use the *Pharmacy Directory*. You can also find information on our member portal, memberportal.navitus.com or ucal.us/medicaresupplement. To access the member portal click on Members, then Login. There is a pharmacy search tool on the member portal, click on *Pharmacy Search* on the top navigation bar.

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 Care.
- 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, look in your *Pharmacy Directory* or call Customer Care.

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order **up to a 90-day supply**. (Specialty drugs are only available for up to a 30-day supply.)

To get order forms and information about filling your prescriptions by mail call Customer Care at 1-833-837-4309. (TTY users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

You may use any contracted pharmacy you like, currently the recommended mail order pharmacy is **Costco Mail Order Pharmacy**. **Note:** Costco Mail Order is not to be confused with Costco Warehouse/Club Stores. You do not need to be a member of Costco Warehouse/Club Stores to utilize Costco Mail Order Pharmacy services.

Costco Mail Order can be reached at 1-800-607-6861. Costco representatives are available Monday through Friday, 7 am to 9 pm Central Time and Saturdays 11:30 am to 4 pm Central Time. Refill orders can be placed and tracked 24 hours a day, 7 days a week. Your physician can send new prescriptions in by calling (1-800-607-6861) or by fax at 1-888-545-4615. Your mail-order pharmacy order should arrive within 14 days.

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

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

Refills on mail-order prescriptions. For refills, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

Note: Both Costco mail order and retail locations are unable to fill Medicare Part B products, for example, Diabetic Testing Strips. Costco can either refer you to an affiliated provider that can fill these supplies, or you can locate a participating retail pharmacy that can process Part B products.

What should I do if I need my mail order prescription urgently from Costco?

Your Costco Mail Order prescriptions should arrive within 14 days. If the medication does not arrive in that timeframe, contact Costco to report that you did not receive your prescription. Costco will verify how many days of medication you have left.

If you have 5 days or less of the medication left, you should contact your doctor to ask for a two-week supply to be called into your local pharmacy.

If you have more than 6 days remaining, Costco will continue to process your order. Costco can expedite shipping your order at an additional cost to you. The overnight shipping happens after the usual processing time of 24 to 96 hours.

In an emergency circumstance where Costco failed to comply with their protocol, they will expedite the patient medication at Costco's cost. If Costco provided unrealistic expectations to you which results in you not getting your medication in time, Costco will investigate and immediately resolve the situation to prevent gaps in therapy.

Please make sure to let the pharmacy know the best ways to contact you to confirm your order before shipping. Communication preferences can be updated by contacting our recommended mail order partner, **Costco Mail Order Pharmacy**.

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. Our plan offers ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition).

1. Some retail pharmacies in our network allow you get a long-term supply of maintenance drugs. Other retail pharmacies may not agree to offer a long-term supply. In this case you may be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Care at 1-833-837-4309 (TTY users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

You may be able to receive greater than a 1-month supply for most of the drugs on your Drug List. Drugs noted with "NDS" (Non-extended Day Supply) on the list are limited to a 1-month supply for retail, mail-order and specialty pharmacies.

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

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. **Check first with Customer Care** to see if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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

- If you are unable to get a covered drug in a timely manner within your area because there are no network pharmacies within a reasonable driving distance that provides 24-hour services.
- If you are trying to fill a covered drug that is not regularly stocked at an eligible network retail pharmacy. (These drugs include orphan drugs or other specialty pharmaceuticals.)
- Please note that out-of-network prescriptions are limited to reimbursement for a single refill of up to a 30-day supply. If you are planning an extended stay in an area without a

network pharmacy, please call Customer Care for assistance in signing up for mail order service.

- If you are filling prescriptions at an out-of-network pharmacy related to a medical emergency.

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 our 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.

How do you ask for reimbursement from the plan?

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

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

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

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

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

We generally cover a drug on our 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 FDA 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.

Certain drugs may be covered for some medical conditions but are considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and on [Medicare.gov](https://www.medicare.gov), along with the specific medical conditions that they cover.

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

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

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

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

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

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

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

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

- **Tier \$0:** Select generics (not all dosages of these drugs are covered at the Select Generics cost share)
- **Tier 1:** Preferred generics and certain lower cost brand products
- **Tier 2:** Preferred brand products and some higher cost non-preferred generics
- **Tier 3:** Non-preferred drugs (could include some higher cost non-preferred generics)
- **Tier 4:** Specialty products

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

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

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

- Check the most recent Drug List we provided electronically. If one of your drugs is not listed in the Drug List, you should visit our member portal, or contact Customer Care to find out if we cover it.
- Visit the member portal (memberportal.navitus.com or ucal.us/medicaresupplement). To log into the member portal click on Members, then Login and follow the instructions. On the top navigation bar of the member portal, click on My Plan, then Forms and Documents to find the Drug List. The Drug List on the member portal is always the most current.
- Call Customer Care to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.
- On the member portal, you can look up drug information which includes cost-sharing information, clinically appropriate Drug List alternatives, when available, and the drug list status of each drug, including any requirements applicable to each alternative drug.

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 our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

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

Note 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 Care 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.)

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.**

The drug list indicates what you will pay for your drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. When a generic drug is available and you or your prescriber choose the brand-name drug, you must pay the applicable brand copay plus the difference between the cost of the brand-name drug and the generic equivalent (referred to as Dispense as Written (DAW) penalty). With a prior authorization request, an exception for medical necessity may be made and you will pay the Tier 3 (non-preferred) applicable copay.

Note: The difference between the cost of the brand drug and the generic (DAW penalty) does not accumulate toward the *UC High Option Supplement to Medicare* Annual Prescription Maximum Out-of-Pocket.

This Dispense as Written (DAW) cost-sharing penalty will not exceed the cost of the medication.

Coverage for out-of-country drugs

Outpatient prescription drugs are not covered by Medicare Part D plans when they are filled by pharmacies outside of the United States.

Your UC plan provides coverage for outpatient prescription drugs when all of the following apply:

- You remain a permanent resident of the United States while you are out of country,
- The drug is approved by the Food and Drug Administration (FDA), *and*
- The drug would be a covered drug by your plan if the drug was filled by a pharmacy located within the United States.

When you receive coverage for outpatient prescription drugs filled at a pharmacy outside the United States, you will need to pay the full cost of the drug and request that we reimburse you for our share. Your share of a covered outpatient drug will be your coinsurance or copayment amount. Please see “How to ask us to pay you back” in Chapter 5, Section 2, for detailed instructions.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our 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 our plan.

Trying a different drug first

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

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 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.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do. Drugs of our Tier 4 (Specialty drugs) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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 our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

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

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

- **If you are a new member**, we will 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 will cover a temporary supply of your drug during the first *90 days* of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:**

We'll cover one 31-day supply 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 questions about a temporary supply, call Customer Care at 1-833-837-4309 (TTY users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

Level of Care Changes

We will provide a one-time 31-day transition supply per drug, which will cover a temporary supply if you have a change in your medications due to a level-of-care change. A level of care change may include:

- Entering or leaving a LTC facility
- Being discharged from a hospital to a home
- Ending a Medicare Part A skilled nursing facility stay
- Giving up hospice status and reverting back to standard Medicare benefits
- Ending an LTC facility stay and returning home

For questions about a temporary supply, call Customer Care at 1-833-837-4309. (TTY users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

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 our plan may work just as well for you. Call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

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

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

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

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 of our Tier 4 (specialty drugs) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

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

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

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

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

Information on changes to drug coverage

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

Changes to drug coverage that affect you during this plan year

Advance General Notice that plan sponsor can make certain immediate generic and biosimilar substitutions: To immediately replace brand name drugs or biological products with, respectively, new therapeutically equivalent or new authorized generic drugs or new interchangeable biological products or new unbranded biological products (or to change the tiering or the restrictions, or both, applied if the related drug stays on the formulary), plan sponsors that otherwise meet the requirements must include this language:

- **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 an 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 take. For example, we 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 changes noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

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

SECTION 7 Types of drugs we don't cover

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

If you get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs covered under our enhanced drug coverage). 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 is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans. Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may be charged an additional premium. More information is provided below:

- 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

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

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. 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 our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our 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 when you fill your prescription, you or the pharmacy can call the plan to get the necessary information by calling 1-833-837-4309. (TTY users should call 711). Hours are 24 hours a day, 7 days a week except on Thanksgiving and Christmas Day.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** You can then **ask us to reimburse you** for our share. Go to Chapter 5, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

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

If you'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* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. There is also a pharmacy search tool on our Member Portal at memberportal.navitus.com or ucal.us/medicaresupplement. If it isn't, or if you need more information or assistance, please contact Customer Care. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

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

Section 9.3 If you are taking drugs covered by Original Medicare

Your enrollment in Navitus MedicareRx 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 Navitus MedicareRx 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 Navitus MedicareRx 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 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 prescription drug coverage for the next calendar year is creditable.

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

Keep 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 safely 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're taking
- Unsafe amounts of opioid pain medications

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

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

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

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

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

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, 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) program to help members manage medications

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

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get

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

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring 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 this program, call Customer Care.

Chapter 4:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We may have 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 have questions whether you should have received this insert, contact Customer Care at 1-833-837-4309 (TTY users call 711) and ask about 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.

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.

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

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

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

Maximum out-of-pocket costs for prescription drugs

Once the maximum out-of-pocket is reached, you pay \$0 for prescription drugs and diabetic supplies for the remainder of the plan year.

Prescription Maximum Out-of-Pocket (Supplement to Medicare)	
UC High Option Supplement to Medicare Plan	\$1,000 *

* Once you reach the \$1,000 UC High Option Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year. **(If the UC Maximum Out-of-Pocket has not been met, the payment responsibility changes after Part D (PDP) TrOOP of \$2,100 is met.)**

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

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

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

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

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

Moving to the Catastrophic Coverage Stage:

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

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

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

- Your monthly premium
- Drugs you buy outside our service area
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage

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

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

Tracking your out-of-pocket total costs

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

SECTION 2 Drug payment stages for Navitus MedicareRx members

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

- **Stage 1: Yearly Deductible Stage**
- **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 moved from one drug payment stage to the next. We track 2 types of costs:

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

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

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows 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 membership 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 a *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 Care. Be sure to keep these reports.

SECTION 4 The Deductible Stage

There is no deductible for Navitus MedicareRx. You begin in the Initial Coverage Stage when you fill your first prescription of the year. Go to 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 four cost-sharing tiers

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

- **Tier \$0** includes select generics
- **Tier 1** includes preferred generics and some lower cost brand products
- **Tier 2** includes preferred brand products and some high cost non-preferred generics
- **Tier 3** includes non-preferred drugs (could include some higher cost non-preferred generics)

- **Tier 4** includes specialty products

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

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 3 and our plan’s *Pharmacy Directory*.

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.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *one-month* supply of a covered Part D drug

Cost-Sharing	Retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (in network) (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing Coverage is limited to certain situations; Chapter 3 has details. (up to a 30-day supply)
Tier \$0 (Select generics; diabetic supplies after Part B pays primary)	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment

Cost-Sharing	Retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (in network) (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing Coverage is limited to certain situations; Chapter 3 has details. (up to a 30-day supply)
Tier 1 (Preferred generics and certain lower cost brand products; insulin & Part D diabetic supplies)	\$15 copayment	\$15 copayment	\$15 copayment	\$15 copayment
Tier 2 (Preferred brand products and some higher cost non-preferred generics; insulin & Part D diabetic supplies)	\$35 copayment	\$35 copayment	\$35 copayment	\$35 copayment
Tier 3 (Non-preferred drugs (could include some higher cost non-preferred generics)	\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment
Tier 4 (Specialty products)	\$35 copayment	\$35 copayment	\$35 copayment	\$35 copayment

You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

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

Your drug copay or coinsurance may be less, based upon the cost of the drug and the coverage stage you are in.

The Drug List indicates what you will pay for your drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. When a generic drug is available and you or your prescriber choose the brand-name drug, you must pay the applicable brand copay *plus* the difference between the cost of the brand-name drug and the generic equivalent (referred to as Dispense as Written (DAW) penalty). With a prior authorization request, an exception for medical necessity may be made and you will pay the Tier 3 (non-preferred) applicable copay.

Note: The difference between the cost of the brand drug and the generic (DAW penalty) does not accumulate toward the *UC High Option Supplement to Medicare* Annual Prescription Maximum Out-of-Pocket.

This Dispense as Written (DAW) cost-sharing penalty will not exceed the cost of the medication.

Maximum Out-of-Pocket

Prescription Maximum Out-of-Pocket (Supplement to Medicare)	
UC High Option Supplement to Medicare Plan	\$1,000 *
* Once you reach the \$1,000 UC High Option Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year. (If the UC Maximum Out-of-Pocket has not been met, the payment responsibility changes after Part D (PDP) TrOOP of \$2,100 is met.)	

Once members reach the \$1,000 UC Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year.

- Out-of-pocket costs for Extra Covered Drugs apply toward the \$1,000 out-of-pocket maximum, but not the Medicare TrOOP of \$2,100.

Extra Covered Drug Benefits (Non-Medicare Part D) – Prescription Required

Drug List Cost Sharing	Select Retail (up to 90 days)
Part B Diabetic Supplies (Navitus MedicareRx will coordinate benefits, if submitted after Medicare Part B pays primary, including lancets, blood sugar diagnostics, calibration solutions and glucometers.)	\$0 copay

Certain drugs that are excluded by law from coverage by Medicare Part D, may be included in the supplemental coverage of your drug plan. Drugs covered under the “Extra Covered Drugs” benefit, will be listed in the drug list.

Extra Covered Drugs Cost Sharing	Retail & Mail Order (up to 30 days)	Retail (31-60 days)	Retail (61-90 days)	Mail Order (31-90 days)
Tier 1 non-Medicare covered drugs	\$15 copay	\$30 copay	\$45 copay	\$30 copay

Tier 2 non-Medicare covered drugs	\$35 copay	\$70 copay	\$105 copay	\$70 copay
Tier 3 non-Medicare covered drugs	\$50 copay	\$100 copay	\$150 copay	\$100 copay

Note: These Extra Covered Drugs do not count towards the Medicare TrOOP (\$2,100) expenses and they do not qualify for lower catastrophic copays.

Member cost share per tier values in the above table, for:

- Cough and Cold Prescriptions
- Erectile Dysfunction (ED) – with quantity limit (QL)
- Vitamins and Minerals Prescriptions

Coverage for Out of Country Drugs: Outpatient prescription drugs are not covered by Medicare Part D plans when they are filled by pharmacies outside of the United States. Your UC plan provides coverage for outpatient prescription drugs when all of the following apply:

- ✓ You remain a permanent resident of the United States while you are out of country, *and*
- ✓ The drug is approved by the Food and Drug Administration (FDA), *and*
- ✓ The drug would be a covered drug by your plan if the drug were filled by a pharmacy located within the United States.

When you receive coverage for outpatient prescription drugs filled at a pharmacy outside the United States, you will need to pay the full cost of the drug and request that we reimburse you for our share. Your share of a covered outpatient drug will be your coinsurance or copayment amount. Please see “How to ask us to pay you back” for detailed instructions, which can be found in the Evidence of Coverage, Chapter 5, Section 2.

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 better plan refill dates.

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 Your costs for a long-term (up to a 90-day) supply of a covered Part D drug

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

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

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.
- Extended supplies (greater than a 1-month supply) may not be available for all medications. To verify if one of your medications is excluded from extended supplies, check the Drug List. Medications which do not qualify for extended supplies will be marked with **NDS (Non-extended Day Supply)**.

Your costs for a *long-term* (90-day) supply of a covered Part D drug

Cost Sharing	Retail cost sharing (in-network) (31-60 day supply)	Retail cost sharing (in-network) (61-90 day supply)	Mail-order cost sharing (in-network) (61-90 day supply)
Tier \$0 (Select generics; diabetic supplies after Part B pays primary)	\$0 copayment	\$0 copayment	\$0 copayment
Tier 1 (Preferred generics and certain lower cost brand products; insulin & Part D diabetic supplies)	\$30 copayment	\$45 copayment	\$30 copayment
Tier 2 (Preferred brand products and some higher cost non-preferred generics; insulin & Part D diabetic supplies)	\$70 copayment	\$105 copayment	\$70 copayment

Cost Sharing	Retail cost sharing (in-network) (31-60 day supply)	Retail cost sharing (in-network) (61-90 day supply)	Mail-order cost sharing (in-network) (61-90 day supply)
Tier 3 (Non-preferred drugs (could include some higher cost non-preferred generics))	\$100 copayment	\$150 copayment	\$100 copayment
Tier 4 (Specialty products)	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4
Extended supplies (greater than a 1-month supply) may not be available for all medications. To verify if your medication is excluded from extended supplies, check the Drug List. Medications which do not qualify for extended supplies will be marked with NDS (Non-extended Day Supply) on the drug list.			

The Drug List indicates what you will pay for your drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. When a generic drug is available and you or your prescriber choose the brand-name drug, you must pay the applicable brand copay *plus* the difference between the cost of the brand-name drug and the generic equivalent (referred to as the **Dispense As Written (DAW)** penalty). With a prior authorization request, an exception for medical necessity may be made and you will pay the Tier 3 (non-preferred) applicable copay.

Note: The difference between the cost of the brand drug and the generic (DAW penalty) does not accumulate toward the *UC High Option Supplement to Medicare* Annual Prescription Maximum Out-of-Pocket.

This Dispense as Written (DAW) cost-sharing penalty will not exceed the cost of the medication.

Maximum Out-of-Pocket

Prescription Maximum Out-of-Pocket (Supplement to Medicare)	
UC High Option Supplement to Medicare Plan	\$1,000 *
* Once you reach the \$1,000 UC High Option Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year. (If the UC Maximum Out-of-Pocket has not been met, the payment responsibility changes after Part D (PDP) TrOOP of \$2,100 is met.)	

“Select Retail” Pharmacies

Select Retail pharmacies include the following retail pharmacies: UC Medical Center retail pharmacies, Costco, CVS, Vons/Safeway, Walmart, and Walgreens.

Select Retail Pharmacy Cost Sharing	Select Retail (up to 90 days)
Tier 1 Drugs from Select Retail Pharmacies	\$30 copay
Tier 2 Drugs from Select Retail Pharmacies	\$70 copay
Tier 3 Drugs from Select Retail Pharmacies	\$100 copay

Extra Covered Drug Benefits (Non-Medicare Part D) – Prescription Required

Durg List Cost Sharing	Select Retail (up to 90 days)
Part B Diabetic Supplies (Navitus MedicareRx will coordinate benefits, if submitted after Medicare Part B pays primary , including lancets, blood sugar diagnostics, calibration solutions and glucometers)	\$0 copay

Certain drugs that are excluded by law from coverage by Medicare Part D, may be included in the supplemental coverage of your drug plan. Drugs covered under the “Extra Covered Drugs” benefit, will be listed in the Drug List.

Extra Covered Drugs Cost Sharing	Retail & Mail Order (up to 30 days)	Retail (31-60 days)	Retail (61-90 days)	Mail Order (31-90 days)
Tier 1 non-Medicare covered drugs	\$15 copay	\$30 copay	\$45 copay	\$30 copay
Tier 2 non-Medicare covered drugs	\$35 copay	\$70 copay	\$105 copay	\$70 copay
Tier 3 non-Medicare covered drugs	\$50 copay	\$100 copay	\$150 copay	\$100 copay

Note: These Extra Covered Drugs do not count towards the Medicare TrOOP (\$2,100) expenses and they do not qualify for lower catastrophic copays.

Member cost share per tier values in the above table, for:

- Cough and Cold Prescriptions
- Erectile Dysfunction (ED) – with quantity limit (QL)
- Vitamins and Minerals Prescriptions

Coverage for Out of Country Drugs: Outpatient prescription drugs are not covered by Medicare Part D plans when they are filled by pharmacies outside of the United States. Your UC plan provides coverage for outpatient prescription drugs when all of the following apply:

- ✓ You remain a permanent resident of the United States while you are out of country, *and*
- ✓ The drug is approved by the Food and Drug Administration (FDA), *and*
- ✓ The drug would be a covered drug by your plan if the drug were filled by a pharmacy located within the United States.

When you receive coverage for outpatient prescription drugs filled at a pharmacy outside the United States, you will need to pay the full cost of the drug and request that we reimburse you for our share. Your share of a covered outpatient drug will be your coinsurance or copayment amount. Please see “How to ask us to pay you back” for detailed instructions, which can be found in the Evidence of Coverage, Chapter 5, Section 2.

You won’t pay more than \$70 for up to a two-month supply or \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,100. You then move to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that aren’t normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won’t count toward your total out-of-pocket costs.

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 during the year. Not all members will reach the \$2,100 out-of-pocket limit in a year.

We’ll let you know if you reach this amount. Go to Section 1.3 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 \$2,100 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.

Note: You may still pay your drug list copayment or coinsurance for Part D excluded drugs that may be covered under your supplemental benefit on the drug list. These drugs have a "*" after the Tier, on the Drug List.

- During this payment stage, you pay nothing for your covered Part D drugs.
- For excluded drugs covered under our enhanced benefit, you may still pay your copayment or coinsurance amount

Cost-Sharing	Retail cost sharing (up to a 30-day supply)	Retail cost sharing (in-network) (31-90 day supply)	Mail-order cost sharing (in network) (up to a 90-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)
Tier \$0 (Select generics; diabetic supplies after Part B pays primary)	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Tier 1 (Preferred generics and certain lower cost brand products; insulin & Part D diabetic supplies)	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Tier 2 (Preferred brand products and some high cost non-preferred generics; insulin & Part D diabetic supplies)	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Tier 3 (Non-preferred drugs (could include some higher cost non- preferred generics)	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Tier 4 (Specialty products)	\$0 copayment	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4	\$0 copayment

The Drug List indicates what you will pay for your drug. A generic drug is the same as a brand-name drug in dosage, safety, and strength. When a generic drug is available and you or your prescriber choose the brand-name drug, you must pay the applicable brand copay *plus* the difference between the cost of the brand-name drug and the generic equivalent (referred to as **Dispense As Written (DAW)** penalty). With a prior authorization request, an exception for medical necessity may be made and you will pay the Tier 3 (non-preferred) applicable copay.

Note: The difference between the cost of the brand drug and the generic (DAW penalty) does not accumulate toward the *UC High Option Supplement to Medicare* Annual Prescription Maximum Out-of-Pocket.

This Dispense as Written (DAW) cost-sharing penalty will not exceed the cost of the medication.

Maximum Out-of-Pocket

Prescription Maximum Out-of-Pocket (Supplement to Medicare)	
UC High Option Supplement to Medicare Plan	\$1,000 *
* Once you reach the \$1,000 UC High Option Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year. (If the UC Maximum Out-of-Pocket has not been met, the payment responsibility changes after Part D (PDP) TrOOP of \$2,100 is met.)	

Once members reach the \$1,000 UC Maximum Out-of-Pocket, the plan covers 100% of the cost of covered drugs until next year.

- Out-of-pocket costs for Extra Covered Drugs apply toward the \$1,000 out-of-pocket maximum, but not the Medicare TrOOP of \$2,100.

Extra Covered Drug Benefits (Non-Medicare Part D) – Prescription Required

Certain drugs that are excluded by law from coverage by Medicare Part D, may be included in the supplemental coverage of your drug plan. Drugs covered under the “Extra Covered Drugs” benefit, will be listed in the drug list.

Extra Covered Drugs Cost Sharing	Retail & Mail Order (up to 30 days)	Retail (31-60 days)	Retail (61-90 days)	Mail Order (31-90 days)
Tier 1 non-Medicare covered drugs	\$15 copay	\$30 copay	\$45 copay	\$30 copay

Tier 2 non-Medicare covered drugs	\$35 copay	\$70 copay	\$105 copay	\$70 copay
Tier 3 non-Medicare covered drugs	\$50 copay	\$100 copay	\$150 copay	\$100 copay

Note: These Extra Covered Drugs do not count towards the Medicare TrOOP (\$2,100) expenses and they do not qualify for lower catastrophic copays.

Member cost share per tier values in the above table, for:

- Cough and Cold Prescriptions
- Erectile Dysfunction (ED) – with quantity limit (QL)
- Vitamins and Minerals Prescriptions

SECTION 7 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 Care for coverage and cost-sharing details about specific vaccines.

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

- 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 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 2.5 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

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

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

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

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

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

- For example, the drug may not be on 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.

Please call Customer Care for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

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

When you send us a request for payment, we'll review your request and decide whether the service or 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 service or 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 documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to us within 36 months** of the date you got the service, item, or drug.

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from the member portal, memberportal.navitus.com or ucal.us/medicaresupplement, or call Customer Care and ask for the form.

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

Navitus MedicareRx
Manual Claims
P.O. Box 1039
Appleton, WI 54912-1039

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 drugs at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the drug, we'll mail your reimbursement of our share of the cost to you. We'll send payment within 30 days after your request was received.
- If we decide the drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your 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 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 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 our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in braille, large print, or other alternate formats at no cost if you need it. 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 Care.

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 Navitus MedicareRx. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Spanish members:

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se proporcionen de manera culturalmente competente y sean accesibles para todos los afiliados, incluidos aquellos con competencia limitada en inglés, habilidades de lectura limitadas, incapacidad auditiva o aquellos con diversos orígenes culturales y étnicos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios gratuitos de interpretación disponibles para responder preguntas de miembros que no hablan inglés. Este documento está disponible de forma gratuita en español. También podemos brindarle información en braille, en letra grande u otros formatos alternativos sin costo si la necesita. Estamos obligados a brindarle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información de nosotros de una manera que le resulte conveniente, llame a Atención al Cliente.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, llame al 1-833-837-4309 para presentar una queja formal ante Navitus MedicareRx (los usuarios de TTY deben llamar al 711). Estamos disponibles las 24 horas del día, los 7 días de la semana, excepto el Día de Acción de Gracias y Navidad. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente a la Oficina de Derechos Civiles al 1-800-368-1019 o 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 are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
 - We're required to release health information to government agencies that are checking on quality of care.
 - Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Customer Care.

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

As a member of Navitus MedicareRx, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Customer Care.

- **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 on why a Part D drug isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make 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 in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **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 call Customer Care to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and 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 state agency. For contact information on the State Medical Assistance Office in your state, please refer to **Exhibit C** or call Customer Care (phone numbers are printed on the back cover of this document).

Section 1.6 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, 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:

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

SECTION 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Care**
- **Call your local SHIP**. For details, go to Chapter 2, Section 3.
- **Contact Medicare**
 - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at: [Medicare Rights & Protections](#))
 - Call 1-800-MEDICARE (1-800-633-4227) (TTY 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 Care.

- **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 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 our plan membership card whenever you get Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - You must pay our plan premiums.
 - 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 are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to 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 *outside* our plan service area, you can't stay a member of our plan.**
- **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 Care 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. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

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](https://www.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 services

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

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is

incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed 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 Care at 1-833-837-4309 (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 Care and ask for the *Appointment of Representative* form. (The form is also available [CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf), or on the member portal, <https://memberportal.navitus.com> or ucal.us/medicaresupplement. 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 services. 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 three 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 will need to pay the cost-sharing amount that applies to drugs in Tier 3. You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug.** Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the 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 four 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 biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
 - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
 - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
 - You can't ask us to change the cost-sharing tier for any drug in Tier 4, designated as specialty.
 - 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 How to ask for a coverage decision, including an exception**Legal Terms:**

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

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

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

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

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

- You must be asking for a drug you didn't get. (You can't ask 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 member portal. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which is available on our member

portal, <https://memberportal.navitus.com> or ucal.us/medicaresupplement. 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're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'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.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to provide **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

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

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

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

Section 5.5 How to 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 Navitus MedicareRx Customer Care at 1-833-837-4309.** 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 member portal. Include your name, contact information, and information about your claim to help us process your request.

- **For electronic submission**, you can go to the member portal, <https://memberportal.navitus.com> or ucal.us/medicaresupplement.
To sign into your Member Portal click on Members, then Login, and complete the *Request for Coverage Determination* form, located under *My Plan, Forms and Documents*. **Note:** If attachments need to be submitted, please fax, or mail the form and supporting documentation. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

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

- When we review your appeal, we take another careful look at all 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. 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. 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 on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within **30 calendar days** after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and 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 send the information we have about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

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

Level 4 appeal

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

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

Level 5 appeal

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

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

Making complaints

SECTION 7 How to make a complaint about quality of care, waiting times, 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 share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • 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 Care 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 <i>timeliness</i> 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 <i>fast coverage decision</i> or a <i>fast appeal</i>, 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.

Complaint	Example
	• 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 is usually the first step.** If there's anything else you need to do, Customer Care 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.
- **When a written complaint is received** in any department of Navitus Health Solutions, it is immediately forwarded to the Navitus MedicareRx Grievance and Appeals Department. All information related to the complaint is collected. You will be advised of the decision no later than 30 calendar days after the date the oral or written complaint is received. Navitus MedicareRx may extend the 30-calendar day timeframe by up to an additional 14 calendar days. Extensions may be given if you request the extension, or if the Grievance and Appeals Department justifies a need for more information. We must inform you of the status of the grievance within 30 days of receipt of the complaint.

You may file for a faster response time when sending an expedited complaint. This request may be filed either verbally or in writing. The same procedures apply for documentation as with standard complaints. However, the Grievance and Appeals Department must notify the member of the decision within 24 hours of receipt of the complaint. The decision is usually presented verbally to the member. Navitus MedicareRx then sends written notice of the decision within three (3) calendar days of the oral notification.

- 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 Navitus MedicareRx directly to Medicare. To submit a complaint to Medicare, go to [Medicare.gov/MedicareComplaintForm/home.aspx](https://www.Medicare.gov/MedicareComplaintForm/home.aspx). You may also call 1-800-MEDICARE (1-800-633-4227). TTY 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 Navitus MedicareRx may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

Please contact your employer group with questions regarding when and how you can end your membership.

- If you decide to change to a new plan after you contacted your employer group, you can choose any of the following types of plans:
 - Another Medicare drug plan,
 - Original Medicare *with* a separate Medicare drug plan,
 - Original Medicare *without* a separate Medicare drug plan,
 - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.
 - A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.

Section 2.1 In certain situations, you can end your membership during a Special Enrollment Period

Members of Navitus MedicareRx are eligible to end their membership at any time of the year. This is known as a **Special Enrollment Period**. **Contact your employer group before ending your membership in Navitus MedicareRx.**

You are eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples; For the full list you can contact your employer group, call Medicare, or visit the [Medicare.gov](https://www.Medicare.gov):

- Have or are leaving employer coverage
- Usually, when you move out of your plan's service area
- If you have Medicaid
- If you're eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, call Customer Care.

Note: If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.

If you get Extra Help from Medicare to pay your drugs coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.3 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Contact your employer group**
- Find the information in the *Medicare & You 2026* handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048)

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan. Contact your employer group before ending your membership in Navitus MedicareRx.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Navitus MedicareRx when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Navitus MedicareRx when your new drug plan's coverage starts.
Original Medicare <i>without</i> a separate Medicare drug plan	• Send us a written request to disenroll. It is important to call or send a written request to disenroll to your benefits administrator. Contact Customer Care if you need more information on how to do this. • You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Navitus MedicareRx when your coverage in Original Medicare starts.

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

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

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

SECTION 5 Navitus MedicareRx must end our plan membership in certain situations

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

- You are no longer eligible under any additional criteria that have been determined by your employer group.
- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.

- If you are away from our service area, call Customer Care to find out if the place you're traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you'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 cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We 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 your membership can end, contact your employer group.

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

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

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

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* 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 nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, 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](https://www.hhs.gov/ocr/index.html).

If you have a disability and need help with access to care, call Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care 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, Navitus MedicareRx, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

CHAPTER 10:

Definitions

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

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

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

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs. During this payment stage, our plan pays the full cost for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

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

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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 after you pay any deductibles, if applicable.

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

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 amounts that a member has to pay when drugs are gotten. 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 gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is gotten.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of four 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 drug coverage later.

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

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

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

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll 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.

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

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 is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also 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, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

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

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

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

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

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

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

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 i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

Medicare-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 our 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).

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

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

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

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

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other 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 gotten is also referred to as the member's out-of-pocket cost requirement.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. 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 Care.

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

Premium – The periodic payment to Medicare, an insurance company, or a 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 and our criteria are posted on the member portal.

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 may disenroll you if you permanently move out of our plan's service area.

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

Standard Cost Sharing – Standard cost sharing is cost sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'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.

Exhibit A - Listing of State Health Insurance Assistance Programs (SHIPs)

Exhibit A - Listing of State Health Insurance Assistance Programs (SHIPs)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

TTY/TDD numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY/TDD number indicated, you may try 711.

Anexo A: Lista de Programas Estatales de Asistencia sobre Seguro Médico (State Health Insurance Assistance Program, SHIP)

SHIP es un programa estatal que recibe dinero del gobierno federal para brindar asesoramiento local gratuito sobre seguros de salud a personas con Medicare.

Los números TTY/TDD requieren equipos telefónicos especiales y son solo para personas que tienen dificultades auditivas o del habla. Si no se indica un número TTY/TDD, puede intentar llamar al 711.

State	Agency Name/Address	Contact Information
Alabama	State Health Insurance Assistance Program (SHIP) 201 Monroe St, Ste 350 Montgomery AL 36104	Toll Free: 1-800-243-5463 Local: 1-334-242-5743 Fax: 1-334-242-5594
Website: http://www.alabamaageline.gov/		
Alaska	Alaska Medicare Information Office (SHIP) 550 W. 8 th Ave Anchorage AK 99501	Toll Free (within AK): 1-800-478-6065 Local (in Anchorage): 1-907-269-3680 Outside AK: Call Anchorage TTY: 1-800-770-8973
Website: http://www.medicare.alaska.gov		
Arizona	State Health Insurance Assistance Program (SHIP) 1789 W. Jefferson St #950A Phoenix AZ 85007	Toll Free: 1-800-432-4040 (leave message) Local: 1-602-542-4446
Website: https://des.az.gov/services/older-adults/medicare-assistance		
Arkansas	Senior Health Insurance Information Program (SHIP) 1200 W. 3 rd St Little Rock AR 72201-1904	Toll Free: 1-800-224-6330 Local: 1-501-371-2782 TTY: 1-501-371-2782
Website: https://insurance.arkansas.gov/pages/consumer-services/senior-health/		

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State	Agency Name/Address	Contact Information
California	California Health Insurance Counseling and Advocacy Program (HICAP) 1300 National Dr, Ste 200 Sacramento CA 95834	Toll Free (within CA): 1-800-434-0222 Toll Free (outside CA): 1-800-677-1116 TTY/TDD: 1-800-735-2929
Website: https://www.aging.ca.gov/hicap/		
Colorado	State Health Insurance Assistance Program 1560 Broadway, Ste 850 Denver CO 80202	Toll Free: 1-888-696-7213 Local: 1-303-894-7855 TTY/TDD: 1-303-894-7880 Spanish: 1-866-665-9668
Website: https://www.colorado.gov/dora/senior-healthcare-medicare		
Connecticut	Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES) 55 Farmington Ave Hartford CT 06105-3730	Toll Free (within CT): 1-800-994-9422 Outside CT: 1-860-424-5274
Website: http://www.ct.gov/agingservices		
Delaware	Delaware Medicare Assistance Bureau (DMAB) 841 Silverlake Blvd Dover DE 19904	Toll Free: 1-800-336-9500 Local: 1-302-674-7364
Website: https://insurance.delaware.gov/divisions/dmab/		
District of Columbia	Health Insurance Counseling Project (HICP) 500 K Street NE Washington DC 20002	Local: 1-202-727-8370 Fax: 1-202-741-5885
Website: https://dcoa.dc.gov/service/health-insurance-counseling		
Florida	Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, Ste 270 Tallahassee FL 32399	Toll Free: 1-800-963-5337 TTY: 1-800-955-8770 Fax: 1-850-414-2150
Website: www.floridashine.org		
Georgia	GeorgiaCares 2 Peachtree St NW, 33 rd Floor Atlanta GA 30303	Toll free: 1-866-552-4464 (Option 4)
Website: www.mygeorgiacares.org		
Hawaii	Hawaii State Health Insurance Assistance Program (SHIP) No 1 Capitol District 250 South Hotel St, Ste 406 Honolulu HI 96813-2831	On the island of Oahu: 1-808-586-7299 Neighbor islands Toll Free: 1-888-875-9229 TTY/TDD: 1-866-810-4379
Website: www.hawaiiiship.org		

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State	Agency Name/Address	Contact Information
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) PO Box 83720 Boise ID 83720-0043	Toll Free: 1-800-247-4422 Local: 1-208-334-4250 Fax: 1-208-334-4389
Website: https://doi.idaho.gov/SHIBA/default		
Illinois	Senior Health Insurance Program (SHIP) One Natural Resources Way #100 Springfield IL 62702-1271	Toll Free: 1-800-252-8966 TTY/TDD: 1-888-206-1327
Website: www.illinois.gov/aging/ship/Pages/default.aspx		
Indiana	State Health Insurance Assistance Program (SHIP) 311 W. Washington St, Ste 300 Indianapolis IN 46204-2787	Toll Free: 1-800-452-4800 TTY/TDD: 1-866-846-0139
Website: www.in.gov/idoi/2495.htm		
Iowa	Senior Health Insurance Information Program (SHIIP) 601 Locust St, 4 th Floor Des Moines IA 50309-3738	Toll Free: 1-800-351-4664 TTY/TDD: 1-800-735-2942
Website: https://shiip.iowa.gov/		
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Ste 612 Topeka KS 66603	Toll Free: 1-800-860-5260 TTY/TDD: 1-800-766-3777 Fax: 1-785-296-0256
Website: https://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick		
Kentucky	State Health Insurance Assistance Program (SHIP) 275 E. Main St 3E-E Frankfort KY 40621	Toll Free: 1-877-293-7447 (Option #2) Local (DAIL): 1-502-564-6930 (Ask for a SHIP counselor) TTY/TDD: 1-888-642-1137
Website: https://chfs.ky.gov/agencies/dail/Pages/ship.aspx		
Louisiana	Senior Health Insurance Information Program (SHIIP) 1702 N 3 rd Baton Rouge LA 70802	Toll Free: 1-800-259-5300 Local: 1-225-342-5301
Website: www.lda.la.gov/consumers/senior-health-shiip		
Maine	Office of Aging and Disability Services 41 Anthony Ave Augusta ME 04333	Toll Free: 1-800-262-2232
Website: http://www.maine.gov/dhhs/oads/community-support/ship.html		
Maryland	Senior Health Insurance Assistance Program (SHIP) 301 W. Preston St, Ste 1007 Baltimore MD 21201	Toll Free: 1-800-243-3425 Local: 1-410-767-1100
Website: http://www.aging.maryland.gov/Pages/StateHealthInsuranceProgram.aspx		

Exhibit A - Listing of State Health Insurance Assistance Programs (SHIPs)

State	Agency Name/Address	Contact Information
Massachusetts	Serving Health Insurance Needs of Elders (SHINE) 1 Ashburton Pl, 5 th Floor Boston MA 02108	Toll Free: 1-800-243-4636 TTY/TDD: 1-877-610-0241
	Website: https://www.mass.gov/health-insurance-counseling	
Michigan	Medicare/Medicaid Assistance Program (MMAP) 6105 W. St Joseph Hwy, Ste 204 Lansing MI 48917	Toll Free: 1-800-803-7174
	Website: http://mmapinc.org/	
Minnesota	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar St St. Paul MN 55155	Toll Free: 1-800-333-2433 TTY/TDD: 1-800-627-3529
	Website: https://www.minnesotahelp.info/index	
Mississippi	State Health Insurance Assistance Program 200 S Lamar St. Jackson, MS 39201	Toll Free: 1-844-822-4622 Local: 1-601-359-4500
	Website: http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/	
Missouri	CLAIM, State Health Insurance Assistance Program (SHIP) 200 N. Keene St., Ste. 101 Columbia, MO 65201	Toll Free: 1-800-390-3330 Local: 1-573-817-8320
	Website: www.missouricclaim.org	
Montana	Montana State Health Insurance Assistance Program (SHIP) 2030 11 th Ave Helena MT 59604	Toll Free: 1-800-551-3191 1-406-444-2590
	Website: http://dphhs.mt.gov/SLTC/aging/SHIP	
Nebraska	Nebraska Senior Health Insurance Information Program 1033 O St. Suite 307 Lincoln, NE 68508	Toll Free: 1-800-234-7119 Local: 1-402-471-2201 TTY/TDD: 1-800-833-7352
	Website: www.doi.nebraska.gov/shiip/	
Nevada	State Health Insurance Assistance Program 3416 Goni Road Suite D-132 Carson City NV 89706	Toll Free: 1-800-307-4444 Local: 1-775-687-4210
	Website: http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/	
New Hampshire	NH ServiceLink Resource Center 2 nd Industrial Park Drive Concord, NH 03302	Toll Free: 1-866-634-9412 Local: 1-603-228-6625 TTY/TDD: 1-800-735-2964
	Website: https://www.servicelink.nh.gov/	

Exhibit A - Listing of State Health Insurance Assistance Programs (SHIPs)

State	Agency Name/Address	Contact Information
New Jersey	State Health Insurance Assistance Program PO Box 715 Trenton NJ 08625-0715	Toll Free: 1-877-222-3737 TTY/TDD: 1-877-486-2048
Website: www.state.nj.us/humanservices/doas/services/ship/		
New Mexico	New Mexico ADRC 2550 Cerrillos Rd Santa Fe NM 87505	Toll Free: 1-800-432-2080 Local: 1-505-476-4799 TTY/TDD: 1-505-476-4937
Website: http://www.nmaging.state.nm.us/		
New York	Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza 4 th Floor Albany NY 12223	Toll Free: 1-800-701-0501 Local: 1-800-342-9871
Website: https://www.shiphelp.org/about-medicare/regional-ship-location/new-york		
North Carolina	Seniors' Health Insurance Information Program 325 N Salisbury St Raleigh, NC 27603	Toll Free: 1-855-408-1212 Local: 1-919-807-6900 TTY/TDD: 1-800-735-2962
Website: www.ncdoi.com/SHIIP/Default.aspx		
North Dakota	State Health Insurance Counseling Program 600 E Boulevard Ave Bismarck, ND 58505	Toll Free: 1-888-575-6611 Local: 1-701-328-2440 TTY/TDD: 1-800-366-6888
Website: www.nd.gov/ndins/shic		
Ohio	Ohio Senior Health Insurance Information Program 50 W. Town St 3 rd Floor, Ste 300 Columbus OH 43215	Toll Free: 1-800-686-1578 Local: 1-614-644-2658 TTY/TDD: 1-614-644-3745
Website: http://www.insurance.ohio.gov/Pages/default.aspx		
Oklahoma	Medicare Assistance Program 5 Corporate Plaza 3625 NW 56 th St, Ste 100 Oklahoma City, OK 73112	Toll Free: 1-800-763-2828 Local: 1-405-521-2828
Website: www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html		
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter St NE Salem OR 97309-2555	Toll Free: 1-800-722-4134 TTY/TDD: 1-800-735-2900
Website: https://healthcare.oregon.gov/shiba/pages/index.aspx		
Pennsylvania	APPRISE Pennsylvania State Health Assistance Program 600 S Wycombe Ave, Yeadon, PA 19050	Toll Free: 1-800-783-7067 Local: 1-484-494-3769
Website: http://www.aging.pa.gov/aging-services/insurance/Pages/default.aspx		

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State	Agency Name/Address	Contact Information
Puerto Rico	State Health Insurance Assistance Program San Juan PR 00907	Toll Free: 1-877-725-4300 TTY/TDD: 1-787-919-7291
	Website: http://www.oppea.pr.gov/	
Rhode Island	Senior Health Insurance Program 57 Howard Ave Louis Pasteur Bldg. 2 nd Floor Cranston RI 02920	Toll Free: 1-888-884-8721 Local: 1-401-462-0510 TTY/TDD: 1-401-462-0740
	Website: www.dea.ri.gov/insurance/	
South Carolina	State Health Insurance Assistance Program (SHIP) 1301 Gervais St, Ste 350 Columbus SC 29201	Toll Free: 1-800-868-9095 Local: 1-803-734-9900
	Website: https://aging.sc.gov/programs-and-initiatives	
South Dakota	Senior Health Information & Insurance Education (SHIINE) 2300 W 46 th St Sioux Falls SD 57105	Toll Free: 1-800-536-8197 Local: 1-605-333-3314
	Website: www.shiine.net	
Tennessee	State Health Insurance Assistance Program 502 Deaderick St, 9 th Floor Nashville TN, 37243-0860	Toll Free: 1-877-801-0044 Local: 1-615-741-2056 TTY/TDD: 1-615-532-3893
	Website: http://tnmedicarehelp.com/	
Texas	Health Information Counseling and Advocacy Program (HICAP) 701 W. 51 st St Austin TX 78751	Toll Free: 1-800-252-9240 TTY/TDD: 1-800-735-2989
	Website: https://hhs.texas.gov/services/health/medicare	
Utah	Senior Health Insurance Information Program 195 N. 1950 W Salt Lake City UT 84116	Toll Free: 1-800-541-7735 Local: 1-801-538-4171
	Website: https://daas.utah.gov/seniors/	
Vermont	State Health Insurance Assistance Program 476 Main St Ste #3 Winooski VT 05404	Toll Free: 1-800-642-5119 Local: 1-802-578-7094
	Website: https://www.vermont4a.org/	
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Ave, Ste 100 Henrico VA 23229	Toll Free: 1-800-552-3402 Local: 1-804-662-9333
	Website: www.vda.virginia.gov/vicap.asp	
Washington	Statewide Health Insurance Benefits Advisors (SHIBA) PO Box 40255 Olympia WA 98504-0255	Toll Free: 1-800-562-6900 TTY/TDD: 1-360-586-0241

Exhibit A - Listing of State Health Insurance Assistance Programs (SHIPs)

State	Agency Name/Address	Contact Information
Website: www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/		
West Virginia	West Virginia State Health Insurance Assistance Program 1900 Kanawha Blvd E Charleston WV 25305	Toll Free: 1-877-987-4463 Local: 1-304-558-3317
Website: www.wvship.org/AboutWVSHIP/tabid/132/Default.aspx		
Wisconsin	Wisconsin State Health Insurance Assistance Program (SHIP) 1 W. Wilson St Madison WI 53703	Toll Free: 1-800-242-1060 Local: 1-608-266-1865 TTY/TDD: 1-866-701-1251
Website: www.dhs.wisconsin.gov/benefit-specialists/ship.htm		
Wyoming	Wyoming State Health Insurance Assistance Program 106 West Adams Ave Riverton WY 82501	Toll Free: 1-800-856-4398 Local: 1-307-856-6880
Website: www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program		

Exhibit B – Listing of Quality Improvement Organizations (QIOs)

Exhibit B - Listing of Quality Improvement Organizations (QIOs)

Region	Address	Contact
1 (CT, ME, MA, NH, RI, VT)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-319-8452 833-868-4055 (fax) 855-843-4776 TTY/TDD
2 (NJ, NY, PR, VI)	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	866-815-5440 833-868-4056 (fax) 866-868-2289 TTY/TDD
3 (DE, DC, MD, PA, VA, WV)	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	888-396-4646 833-868-4057 (fax) 888-985-2660 TTY/TDD
4 (AL, FL, GA, KY, MS, NC, SC, TN)	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	888-317-0751 833-868-4058 (fax) 855-843-4776 TTY/TDD
5 (IL, IN, MI, MN, OH, WI)	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	888-524-9900 833-868-4059 (fax) 888-985-8775 TTY/TDD
6 (AR, LA, NM, OK, TX)	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	888-315-0636 833-868-4060 (fax) 855-843-4776 TTY/TDD
7 (IA, KS, MO, NE)	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	888-755-5580 833-868-4061 (fax) 888-985-9295 TTY/TDD
8 (CO, MT, ND, SD, UT, WY)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-317-0891 833-868-4062 (fax) 855-843-4776 TTY/TDD
9 (AZ, CA, HI, NV)	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701	877-588-1123 833-868-4063 (fax) 855-887-6668 TTY/TDD
10 (AK, ID, OR, WA)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-305-6759 833-868-4064 (fax) 855-843-4776 TTY/TDD

TTY/TDD numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking

Exhibit C – Listing of State Medical Assistance Offices (Medicaid)Exhibit C - Listing of State Medical Assistance Offices
(Medicaid)

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
Alabama	Medicaid Agency of Alabama	501 Dexter Ave PO Box 5624 Montgomery AL 36103-5624	1-800-362-1504 www.medicaid.alabama.gov
Alaska	Alaska Department of Health and Social Services	350 Main St Rm 304 PO Box 110640 Juneau AK 99811-0640	1-800-780-9972 http://dhss.alaska.gov
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	801 E. Jefferson St Phoenix AZ 85034	1-855-432-7587 www.azahcccs.gov
Arkansas	Arkansas Medicaid	PO Box 1437 Slot S401 Little Rock AR 72203-1437	1-800-482-8988 1-800-285-1131 x26789 (TTY/TDD) * https://medicaid.mmis.arkansas.gov
California	Medi-Cal	PO Box 997417 MS 4607 Sacramento CA 95899-7417	1-800-541-5555 1-916-636-1980 (outside California) https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx
Colorado	Health First Colorado	1570 Grant St Denver CO 80203-1818	1-800-221-3943 TTY/TDD: 711 www.colorado.gov/hcpf
Connecticut	Husky Health	55 Farmington Ave Hartford CT 06105-3730	1-877-284-8759 1-866-492-5276 (TTY/TDD) * http://www.ct.gov/hh/
Delaware	Diamond State Health	1901 N. Dupont Hwy New Castle DE 19720	1-866-843-7212 1-302-571-4900 http://www.dhss.delaware.gov/dss/medicaid.html
District of Columbia	DC Medicaid	441 4 th St NW 900S Washington DC 20001	1-202-727-5355 www.dc-medicaid.com
Florida	Statewide Medicaid Managed Care	2727 Mahan DrMail Stop #8 Tallahassee FL 32308	1-877-254-1055 1-866-467-4970 (TTY/TDD) * www.fdhc.state.fl.us/Medicaid
Georgia	Georgia Medicaid	2 Peachtree St NW Atlanta GA 30303	1-866-211-0950 https://dch.georgia.gov/medicaid

Exhibit C – Listing of State Medical Assistance Offices (Medicaid)

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
Hawaii	Hawaii QUEST	801 Dillingham Blvd 3 rd Floor Honolulu HI 96817	Oahu: 1-808-524-3370 TTY/TDD: 1-808-692-7182* Neighbor Islands: 1-800-316-8005 TTY/TDD 1-800-603-1201 * https://medquest.hawaii.gov
Idaho	Idaho Medicaid	1720 N Westgate Dr Boise ID 83704	1-877-456-1233 1-208-334-6801 (TTY/TDD) * http://www.medicaid.idaho.gov/
Illinois	HFS Medical Benefits	201 S. Grand Ave E. 2 nd Springfield IL 62704-0001	1-800-843-6154 1-800-447-6404 (TTY/TDD) * http://www.illinois.gov/hfs/
Indiana	Hoosier Healthwise	PO Box 1810 Marion IN 46952	1-800-457-4584 https://fssabenefits.in.gov
Iowa	IA Health Link	1305 E Walnut St Des Moines IA 50319	1-800-338-8366 1-800-735-2942 (TTY/TDD) * http://dhs.iowa.gov/iahealthlink
Kansas	KanCare	900 SW Jackson St Ste 900N Topeka KS 66612	1-800-792-4884 www.kancare.ks.gov
Kentucky	Kentucky Medicaid	275 E Main St 6W-A Frankfurt KY 40602	1-855-306-8959 https://chfs.ky.gov/
Louisiana	Healthy Louisiana	PO Box 629 Baton Rouge LA 70821-0629	1-888-342-6207 1-855-526-3346 (TTY/TDD) * www.bayouhealth.com
Maine	MaineCare	114 Corn Shop Ln Farmington ME 04938	1-855-797-4357 TTY/TDD: 711 * https://www.maine.gov/DHHS/oms
Maryland	Maryland Medicaid	201 W Preston St Baltimore MD 21201	1-877-463-3464 1-410-767-6500 mmcp.dhmdh.maryland.gov
Massachusetts	MassHealth	PO Box 290794 Charleston MA 02129	1-800-841-2900 1-800-497-4648 (TTY/TDD) * www.mass.gov/masshealth
Michigan	Michigan Medicaid Program	333 S Grand Ave PO Box 30195 Lansing MI 48909	1-800-642-3195 1-800-649-3777 (TTY/TDD) * www.michigan.gov/medicaid
Minnesota	MinnesotaCare	PO Box 64838 St Paul MN 55164	1-800-657-3672 http://mn.gov/dhs
Mississippi	Mississippi Medicaid	550 High St Ste 1000 Jackson MS 39201-1399	1-800-421-2408 www.medicaid.ms.gov

Exhibit C – Listing of State Medical Assistance Offices (Medicaid)

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
Missouri	MO HealthNet	615 Howerton Ct PO Box 6500 Jefferson City MO 65102-6500	1-800-392-2161 www.dss.mo.gov/fsd
Montana	Montana Medicaid	1400 Broadway Cogswell Bldg Helena MT 59620	1-800-362-8312 https://apply.mt.gov
Nebraska	Access Nebraska	301 Centennial Mall S. PO Box 95026 Lincoln NE 68509	1-855-632-7633 1-402-471-9570 (TTY/TDD) * www.accessnebraska.ne.gov
Nevada	Nevada Medicaid	1210 S. Valley View Suite 104 Las Vegas NV 89102	1-800-992-0900 https://dwss.nv.gov/
New Hampshire	NH Health Protection Program	129 Pleasant St Concord NH 03301-3852	1-888-901-4999 1-800-735-2964 (TTY/TDD) * http://www.dhhs.nh.gov/ombp/
New Jersey	NJ FamilyCare	7 Quakerbridge Plaza PO Box 712 Trenton NJ 08619	1-800-356-1561 http://www.state.nj.us/humanservices
New Mexico	Centennial Care	PO Box 2348 Santa Fe NM 87504-2348	1-800-283-4465 http://www.hsd.state.nm.us/
New York	New York Medicaid	1466 Corning Tower Albany NY 12237	1-800-541-2831 www.health.ny.gov
North Carolina	North Carolina Medicaid	220 Swinburne St PO Box 46833 Raleigh NC 27620	1-800-662-7030 1-877-733-4851 (TTY/TDD) * https://dma.ncdhhs.gov/medicaid/
North Dakota	North Dakota Medicaid	600 E. Boulevard Ave Dept 325 Bismarck, ND 58505-0250	1-844-854-4825 1-800-366-6888 (TTY/TDD) * http://www.nd.gov/dhs/eligibility/
Ohio	Ohio Medicaid	50 W. Town St Ste 400 Columbus OH 43215	1-800-324-8680 http://www.medicaid.ohio.gov
Oklahoma	SoonerCare	4345 N. Lincoln Blvd Oklahoma City OK 73105	1-800-987-7767 http://www.okhca.org/

Exhibit C – Listing of State Medical Assistance Offices (Medicaid)

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
Oregon	Oregon Health Plan	500 Summer St NE Salem OR 97301	1-800-699-9075 http://healthcare.oregon.gov/
Pennsylvania	Pennsylvania Medicaid	625 Forester St Rm 515 PO Box 2675 Harrisburg PA 17105	1-800-692-7462 1-717-705-7103 (TTY/TDD) * http://www.dhs.pa.gov/citizens/healthcare/medicalassistance/
Puerto Rico	Puerto Rico Medicaid	PO Box 70184 San Juan PR 00936	1-787-765-6000 www.medicaid.pr.gov
Rhode Island	Rhody Health Options	57 Howard Ave Cranston RI 02920	1-800-984-8989 1-401-462-0740 (TTY/TDD) * http://www.eohhs.ri.gov/
South Carolina	Healthy Connections	PO Box 100101 Columbia SC 29202	1-888-549-0820 www.scdhhs.gov
South Dakota	South Dakota Medicaid	700 Governors Dr Pierre SD 57501	1-800-226-1033 http://dss.sd.gov/medicaid/
Tennessee	TennCare	310 Great Circle Rd Nashville TN 37243	1-800-342-3145 1-877-779-3103 (TTY/TDD) * www.tn.gov/tenncare/
Texas	Texas Medicaid	4900 N. Lamar Blvd Austin TX 78751	1-800-252-8263 1-512-424-6597 (TTY/TDD) * www.yourtexasbenefits.com
Utah	Utah Medicaid	288 N. 1460 West PO Box 143106 Salt Lake City UT 84114	1-800-662-9651 https://medicaid.utah.gov/
Vermont	Vermont Medicaid	103 S. Main St Waterbury VT 05671-0204	1-800-250-8427 http://dcf.vermont.gov/benefits/MABD
Virginia	Virginia Medicaid	600 E. Broad St Ste 1300 Richmond VA 23219	1-804-786-7933 1-800-343-0634 (TTY/TDD) * http://www.dmas.virginia.gov/
Washington	Washington Apple Health	PO Box 45502 Olympia WA 98504-5502	1-800-562-3022 1-360-586-0226 (TTY/TDD) * http://www.hca.wa.gov/Medicaid

Exhibit C – Listing of State Medical Assistance Offices (Medicaid)

STATE	PROGRAM NAME	ADDRESS	PHONE NUMBERS/WEBSITES
West Virginia	WV Medicaid	350 Capitol St Rm 251 Charleston WV 25301	1-888-483-0797 http://www.dhhr.wv.gov/
Wisconsin	ForwardHealth	1 West Wilson St Madison WI 53703	1-800-362-3002 1-888-701-1251 (TTY/TDD) * www.forwardhealth.wi.gov
Wyoming	Wyoming Medicaid	401 Hathaway Bldg Cheyenne WY 82002	1-866-571-0944 https://health.wyo.gov

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

Exhibit D – Listing of State Pharmaceutical Assistance Programs (SPAP)

Exhibit D - Listing of State Pharmaceutical Assistance Programs (SPAPs)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Colorado	Colorado Bridging the Gap	Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246	1-303-692-2716 1-303-692-2783
	https://www.colorado.gov		
Connecticut	Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program (ConnPACE)	PO Box 5011 Hartford CT 06102	1-860-269-2029 (Hartford/Farmington and out-of-state) 1-800-423-5026 (in-state only)
	https://portal.ct.gov/dors		
Delaware	Delaware Prescription Assistance Program	PO Box 950 New Castle DE 19720	1-800-996-9969 Ext:2
	https://www.dhss.delaware.gov/dhss/dmma/dpap.html		
Idaho	IdaGAP	PO Box 83720 Boise ID 83720	1-208-334-5612
	http://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment		
Indiana	HoosierRx	402 W. Washington St Room W374, MS07 Indianapolis IN 46204	1-866-267-4679
	https://www.payingforseniorcare.com/pharmaceutical-assistance/in-hoosierx.html		
Massachusetts	Massachusetts Prescription Advantage	PO Box 15153 Worcester MA 01615	1-800-243-4636 Ext: 2 TTY/TDD (877) 610-0241
	https://www.mass.gov/prescription-drug-assistance		
Maryland	Maryland SPAP	c/o Pool Administrators 628 Hebron Ave Ste 502 Glastonbury CT 06033	1-800-551-5995 TTY/TDD 1-800-877-5156
	http://marylandspdap.com/		
Maine	MaineCare Services	242 State St Augusta ME 04333	1-866-796-2463
	https://www.maine.gov/dhhs/oads/community-support/medicare-assistance.html		
Missouri	Missouri Rx Plan	PO Box 6500 Jefferson City MO 65102	1-800-375-1406
	https://www.payingforseniorcare.com/pharmaceutical-assistance/mo-missouri-rx-plan.html		

Exhibit D – Listing of State Pharmaceutical Assistance Programs (SPAP)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Montana	Montana Big Sky Rx Program	PO Box 202915 Helena MT 59620	1-866-369-1233 https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky
North Carolina	North Carolina SPAP	1902 Mail Service Center Raleigh NC 27699	1-877-466-2232 https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html
New Jersey	NJ Senior Gold Prescription Discount Program	PO Box 715 Trenton NJ 08625	1-800-792-9745 https://www.state.nj.us/humanservices/doas/services/seniorgold/
Nevada	Nevada Senior Rx	3416 Goni Road Ste D-132 Carson City NV 89706	1-866-303-6323 Option 2 702-486-4307 http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/
New York	New York EPIC	PO Box 15018 Albany NY 12212	1-800-332-3742 http://www.health.ny.gov/health_care/epic/ https://www.health.ny.gov/health_care/epic/
Pennsylvania	PACE	PO Box 8806 Harrisburg PA 17105	1-800-225-7223 https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
Rhode Island	RIPAE	74 West Rd Cranston RI 02920	1-401-462-3000 https://www.payingforseniorcare.com/pharmaceutical-assistance/ri-ripae.html
Texas	Texas KHC	PO Box 149347 Austin TX 78714	1-800-222-3986 https://hhs.texas.gov/services/health/kidney-health-care
Virginia	Virginia SPAP	109 Governor St Richmond VA 23219	1-855-362-0658 http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/
Vermont	VPharm	312 Hurricane Ln Ste 201 Williston VT 05495	1-800-250-8427 https://www.payingforseniorcare.com/pharmaceutical-assistance/vt-vpharm-vhap-vscript.html
Washington	Washington State Health Insurance Pool	PO Box 1090 Great Bend KS 67530	1-800-877-5187 https://www.wship.org/Default.asp
Wisconsin	SeniorCare	PO Box 6710 Madison WI 53716	1-800-657-2038 https://www.dhs.wisconsin.gov/seniorcare/index.htm

Exhibit E – Listing of State AIDS Drug Assistance Programs (ADAP)

Exhibit E - Listing of State AIDS Drug Assistance Programs (ADAPs)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Alabama	Alabama ADAP	201 Monroe St Ste 1400 Montgomery AL 36104	1-866-574-9964
http://www.adph.org/aids/index.asp			
Alaska	Alaska ADAP	3601 C Street Ste 540 Anchorage AK 99503	1-907-269-8058
http://www.adph.org/aids/index.asp			
Arizona	Arizona ADAP	150 N. 18 th Ave, Ste 110 Phoenix AZ 85007	1-800-334-1540
http://www.azdhs.gov/phs/hiv/adap/			
Arkansas	Arkansas ADAP	4815 W. Markham Little Rock AR 72205	1-800-232-4636
http://www.healthy.arkansas.gov/programsServices/infectiousDisease/			
California	California ADAP	1616 Capitol Ave, Ste 616 Sacramento CA 95814	1-888-311-7632
https://www.cdph.ca.gov/Programs/CID/DOA/pages/OA_adap_eligibility.aspx			
Colorado	Colorado ADAP	4300 Cherry Creek Dr South Denver CO 80246	1-303-692-2716
https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap			
Connecticut	Connecticut ADAP	25 Sigourney St Hartford CT 06106	1-800-233-2503
http://www.ct.gov/dss/lib/dss/PDFs/CADAPapp03.pdf			
Delaware	Delaware ADAP	540 DuPoint Hwy Dover DE 19901	1-302-739-3032
http://www.dhss.delaware.gov/dph/dpc/hivtreatment.html			
District of Columbia	DC ADAP	899 North Capitol St NE Washington DC 20002	1-202-671-4900
http://doh.dc.gov/service/dc-aids-drug-assistance-program			

Exhibit E – Listing of State AIDS Drugs Assistance Programs (ADAP)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Florida	Florida ADAP	4052 Bald Cypress Way Tallahassee FL 32399 http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	1-850-245-4335
Georgia	Georgia ADAP	2 Peachtree St NW Ste 12-235 Atlanta GA 30303 https://dph.georgia.gov/adap-program	1-404-657-3127
Hawaii	Hawaii ADAP	3627 Kilauea Ave Ste 306 Honolulu HI 96816 http://www.idph.state.il.us/health/aids/adap.htm	1-808-732-0026
Illinois	Illinois ADAP	525 West Jefferson St 1 st Floor Springfield IL 62761 http://www.idph.state.il.us/health/aids/adap.htm	1-800-547-0466
Idaho	Idaho ADAP	450 W. State St PO Box 837220 Boise ID 83720 http://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare	1-800-926-2588
Indiana	Ryan White Program	2 N Meridan St Indianapolis IN 46204 https://www.in.gov/isdh/17740.htm	1-866-588-4948
Iowa	Iowa ADAP	321 E 12 th St Des Moines IA 50319 http://idph.iowa.gov/hivstdhep/hiv/support	1-888-346-9562
Kansas	Kansas ADAP	1000 SW Jackson Ste 210 Topeka KS 66612 http://www.kdheks.gov/sti_hiv/ryan_white_care.htm	1-785-296-8701
Kentucky	Kentucky ADAP	275 E. Main St 1E-B Frankfort KY 40621 http://chfs.ky.gov/dph/epi/hivaids/services.htm	1-800-420-7431

Exhibit E – Listing of State AIDS Drugs Assistance Programs (ADAP)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Louisiana	Louisiana Health Access Program	1450 Poydras St Ste 2136 New Orleans LA 70112	1-504-568-7474
		http://new.dhh.louisiana.gov/index.cfm/page/1118	
Maine	Maine ADAP	221 State St Augusta ME 04333	1-800-851-8437
		http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml	
Maryland	Maryland ADAP	201 W. Preston St Baltimore MD 21201	1-800-205-6308
		http://phpa.dhmdh.maryland.gov/OIDPCS/CHCS/pages/madap.aspx	
Massachusetts	Community Research Initiative of New England/HDAP	38 Chauncy St Ste 500 Boston MA 02111	1-800-228-2714
		http://crine.org/hdap/contact-us/	
Michigan	MiDAP	109 Michigan Ave 9 th Floor Lansing MI 48913	1-888-826-6565
		http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982---,00.html	
Minnesota	MN ADAP	PO Box 64972 St Paul MN 55164	1-800-657-3761
			1-800-627-3529 (TTY/TDD) *
		https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/	
Mississippi	Mississippi ADAP	570 E. Woodrow Wilson PO Box 1700 Jackson MS 39215-1700	1-888-343-7373
		http://msdh.ms.gov/msdhsite/_static/14,13047,150.html	

Exhibit E – Listing of State AIDS Drugs Assistance Programs (ADAP)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
Missouri	Missouri HIV/AIDS Case Management Program	PO Box 570 Jefferson City MO 65102-0570	1-800-785-2437
		https://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php	
Montana	Montana ADAP	1400 Broadway Room C-211 Helena MT 59620	1-406-444-3565
		https://adap.directory/montana	
Nebraska	Nebraska ADAP/CARE	301 Centennial Mall S. Lincoln NE 68509	1-800-782-2437
		http://dhhs.ne.gov/publichealth/Pages/dpc_ryan_white.aspx	
Nevada	Nevada Ryan White	4126 Technology Way, Ste 200 Carson City NV 89706	1-877-385-2345
		http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/	
New Hampshire	New Hampshire Ryan White CARE	129 Pleasant St Concord NH 03301-3852	1-800-852-3345
		http://www.dhhs.nh.gov/dphs/bchs/std/care.htm	
New Jersey	NJ AIDS Drug Distribution Program	PO Box 722 Trenton NJ 08625-0722	1-877-613-4533
		https://adap.directory/new-jersey	
New Mexico	NM AIDS Drug Assistance	PO Box 830 Bernalillo NM 87004	1-855-637-6574
		https://nmhealth.org/about/phd/idb/hats/	
New York	HIV Uninsured CARE	PO Box 2052 Albany NY 12220-0052	1-800-542-2437 1-518-459-0121 (TTY/TDD) *
		http://www.health.ny.gov/diseases/aids/general/resources/adap/	
North Carolina	NC ADAP	1902 Mail Service Center Raleigh NC 27699	1-877-466-2232
		http://epi.publichealth.nc.gov/cd/hiv/adap.html	

Exhibit E – Listing of State AIDS Drugs Assistance Programs (ADAP)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
North Dakota	Ryan White HIV/AIDS Program	2635 E. Main Ave Bismarck ND 58506	1-800-472-2180
		https://www.ndhealth.gov/HIV/HIV%20Care/ADAP/ADAP.htm	
Ohio	Ohio HIV Drug Assistance Program	246 N. High St Columbus OH 43215	1-800-777-4775
		https://www.odh.ohio.gov/odhprograms/hastpac/hivcare/OHDAP/drgasst1.aspx	
Oklahoma	Oklahoma ADAP	1000 NE Tenth Rm 614 Oklahoma City OK 73117	1-800-884-1572
		https://www.ok.gov/health2/documents/HIV-HDAPbrochure14.pdf	
Oregon	CAREassist	PO Box 14450 Portland OR 97293	1-800-805-2313
		https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREassist	
Pennsylvania	Special Pharmaceutical Benefits Program	PO Box 8808 Harrisburg PA 17105-8808	1-800-922-9384
		https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx	
Puerto Rico	Ryan White Program	PO Box 70184 San Juan PR 00936-8184	1-787-765-2929
		http://www.salud.gov.pr/Servicios-al-Ciudadano/Pages/default.aspx	
Rhode Island	Ryan White Program	74 West Rd Ste 60 Cranston RI 02920	1-401-462-3294
		http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ADAPEnrollmentForm.pdf	
South Carolina	SC ADAP	PO Box 101106 Columbia SC 29211	1-800-856-9954
		http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/	
South Dakota	Ryan White Program	615 E. 4 th St Pierre SD 57501	1-800-592-1861
		http://doh.sd.gov/diseases/infectious/ryanwhite/	
Tennessee	Ryan White Program	425 5 th Ave N. 3 rd Fl Nashville TN 37243	1-800- 525-2437

Exhibit E – Listing of State AIDS Drugs Assistance Programs (ADAP)

STATE	AGENCY	ADDRESS	PHONE NUMBERS
http://www.tn.gov/health/topic/STD-ryanwhite			
Texas	Texas HIV Medication Program	PO Box 149347 MC 1873 Austin TX 78714	1-800-255-1090
https://www.dshs.texas.gov/hivstd/meds/document.shtm			
Utah	Utah ADAP	PO Box 142104 Salt Lake City UT 84114-2104	1-801-538-6197
http://health.utah.gov/epi/treatment/			
Vermont	VT Medication Assistance Program	108 Cherry St Burlington VT 05402	1-802-863-7245
http://healthvermont.gov/prevent/aids/aids_index.aspx			
Virginia	Virginia ADAP	VA Dept of Health 109 Governor St, 1 st Floor Richmond VA 23219	1-855-362-0658
http://166.67.66.226/epidemiology/DiseasePrevention/Programs/ADAP/			
Washington	Early Intervention Program	PO Box 47841 Olympia WA 98504-7841	1-877-376-9316
http://www.doh.wa.gov/portals/1/documents/pubs/430-025-EIPBrochure.pdf			
West Virginia	WV ADAP	PO Box 6360 Wheeling WV 26003	1-304-232-6822
http://www.dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx			
Wisconsin	WI ADAP	PO Box 2659 Madison WI 53701-2659	1-800-991-5532
https://www.dhs.wisconsin.gov/aids-hiv/adap.htm			
Wyoming	Communicable Disease Services Program	401 Hathaway Building Cheyenne WY 82002	1-307-777-7529
https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/forms/			