2027
Evidence of Coverage (EOC)

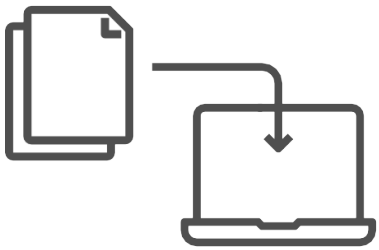
UMP Classic Medicare with Part D (PDP)





S5975-808

Get plan documents delivered to you online



Online documents give you easy access to all your UMP Classic Medicare with Part D (PDP) information.

To receive an email notification from ArrayRx when new documents are available, instead of receiving notifications in the mail, visit **ump.regence.com/ump/signin** and log in to your prescription drug Member Dashboard. If you don't have a Regence account, you can create one.

Once logged in, select Coverage. Next, select the Pharmacy tab, then select Access Benefits and select OK. You can also access your prescription drug Member Dashboard directly through ArrayRx at **ArrayRxSolutions.com/UMP**.

From there, under Contact Info, you can update your email address and your electronic delivery preferences for your Explanation of Benefits (EOBs) and Medicare mailings.

Once you request electronic delivery, you will no longer receive hard copy documents in the mail, unless you request them.

Questions? Call ArrayRx Customer Service at 1-833-599-8539 (TTY 711) or visit **ArrayRxSolutions.com/UMP**.

Uniform Medical Plan ArrayRx

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-599-8539 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se dispone de forma gratuita de ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-833-599-8539 (TTY: 711) o hable con su proveedor.

Chinese: 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-833-599-8539（文本电话：711）或咨询您的服务提供商。

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-833-599-8539 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Korean: 주의: 한국어를 구사하는 경우 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 1-833-599-8539(TTY: 711)로 전화하거나 제공업체에 문의하십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-599-8539 (TTY: 711) или обратитесь к своему поставщику услуг.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-833-599-8539 (TTY: 711) o makipag-usap sa iyong provider.

Ukrainian: УВАГА: Якщо Ви володієте українською мовою, Вам доступні безкоштовні послуги мовної допомоги. Відповідні допоміжні засоби та послуги з надання інформації в доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-833-599-8539 (телетайп: 711) або зверніться до свого постачальника».

Uniform Medical Plan ArrayRx

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

Khmer: សូមយកចិត្តទុក ជាក់ប្រសិនបើអ្នកនិយាយ ភាសា ខ្មែរសេវាកម្មជំនួយភាសា ឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្ម ដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ ដែល ចូលប្រើបានក៏ ចេញឥតគិតថ្លៃដែរ។ ហៅទូរស័ព្ទ 1-833-599-8539 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Japanese: 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-833-599-8539（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

Amharic: ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-833-599-8539 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

Somali: FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-833-599-8539 (TTY: 711) ama la hadal bixiyahaaga.

Arabic:

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-833-599-8539 (TTY 711) أو تحدث إلى مقدم الخدمة".

Panjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਉਚਿਤ ਸਹਾਇਕ ਸਹਾਇਤਾਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। 1-833-599-8539 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਨਕ ਨਾਲ ਗਿੱਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachhilfen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-833-599-8539 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter.

Laotian: ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-833-599-8539 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Uniform Medical Plan ArrayRx

Important documents for your Part D prescription drug plan

The documents below describe your benefits and coverage rules:



Evidence of Coverage (EOC)

The EOC shows all of your prescription drug coverage details. Use it to find out how to get coverage for the prescriptions you need. Every year, we post the following year's EOC online at **ArrayRxSolutions.com/UMP** by October 15.



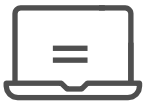
Pharmacy Directory

The directory lists in-network pharmacies available to you. Visit **ArrayRxSolutions.com/UMP** to access this document or our online searchable directory, the Pharmacy Locator Tool.



List of Covered Prescription Drugs (Formulary)

The Formulary tells which Part D prescription drugs, including certain covered non-Part D prescription drugs and related supplies (identified by an * at the end of the listing), are covered under the Part D benefit for your plan. Visit **ArrayRxSolutions.com/UMP** to access this document and get an estimate of what you'll pay, using our Drug Price Estimator tool.



You can also view your plan documents by logging into your prescription drug Member Dashboard at ArrayRxSolutions.com/UMP.

If you would like any of these documents mailed to you, or you have questions of your prescription drug coverage, contact ArrayRx Customer Service: 1-833-599-8539 (TTY 711) or UMPRXMedicare@modahealth.com.

UMP Classic Medicare with Part D (PDP) is a Public Employee Benefits Board (PEBB) employer group plan. Moda Health Plan, Inc. administers the Part D prescription drug benefit for ArrayRx and holds a contract with Medicare. Enrollment in UMP Classic Medicare with Part D (PDP) depends on contract renewal.

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Uniform Medical Plan ArrayRx

January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Drug Coverage as a Member of UMP Classic Medicare with Part D (PDP)

This document gives the details of your Medicare drug coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

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

For questions about this document, call ArrayRx Customer Service at 1-833-599-8539. (TTY users should call 711). Hours are 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. This call is free.

This plan, UMP Classic Medicare with Part D (PDP), is offered by Moda Health, Inc. Moda is the administrator of ArrayRx. (When this *Evidence of Coverage* says "we," "us," or "our," it means Moda Health, Inc., administrator of ArrayRx. When it says "plan" or "our plan," it means UMP Classic Medicare with Part D (PDP).)

This information is available in large print. Please call ArrayRx Customer Service if you need plan information in another format or language.

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

Our formulary, pharmacy network, and/or provider network may change at any time.

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

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CHAPTER 1:
Get started as a member

Section 1 You're a member of UMP Classic Medicare with Part D (PDP)

Section 1.1 You're enrolled in UMP Classic Medicare with Part D (PDP), which is a Medicare Drug Plan

You're covered by Original Medicare (Part A & Part B) and have chosen to enroll in UMP Classic Medicare with Part D (PDP). Our plan includes your Medicare Part D prescription drug coverage.

This Evidence of Coverage is specific to the Part D prescription drug coverage under your UMP Classic Medicare with Part D (PDP) plan.

Like all Medicare plans, this Part D prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 Legal information about the Evidence of Coverage

This *Evidence of Coverage* is part of our contract with you about how UMP Classic Medicare with Part D (PDP) 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 UMP Classic Medicare with Part D (PDP) between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of UMP Classic Medicare with Part D (PDP) after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

Section 2 Plan Eligibility Requirements

Section 2.1 Eligibility Requirements

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

- You meet the eligibility requirements for the Public Employees Benefits Board (PEBB) Program coverage and are eligible for enrollment in the UMP Classic Medicare with Part D (PDP) plan.
- 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 national, or an eligible noncitizen.

Section 2.2 Plan service area for UMP Classic Medicare with Part D (PDP)

UMP Classic Medicare with Part D (PDP) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes the United States, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. If you move out of our plan's service area, you can't stay a member of this plan. The Public Employees Benefits Board (PEBB) Program may terminate or defer your enrollment in this plan. (Go to Chapter 8, Section 5 for more information).

When you move, you'll have a Special Enrollment Period under Medicare to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

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

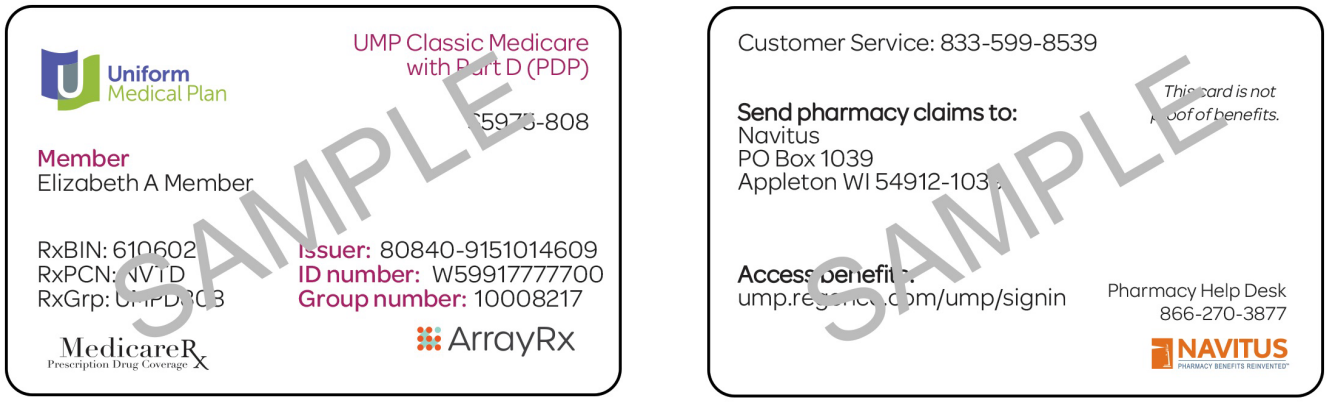
Section 2.3 U.S. citizen or national, or eligible noncitizen

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

Section 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card, also called your prescription drug member identification (ID) 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 UMP Classic Medicare with Part D (PDP) plan membership card is damaged, lost, or stolen, call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711) right away and we'll send you a new card.

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare along with your member identification (ID) cards you received for UMP Classic Medicare with Part D (PDP). You will have one ID card for your prescription drug coverage, as seen above, as well as a separate ID card for your medical coverage through UMP Classic Medicare with Part D (PDP).

Section 3.2 Pharmacy Directory

The *Pharmacy Directory* located at **ArrayRxSolutions.com/UMP** lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan

members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 3, Section 2.4 for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a *Pharmacy Directory*, you can ask for a copy from ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711). You can also find this information on our website at **ArrayRxSolutions.com/UMP**.

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 and any covered bonus non-Part D prescription drugs and related supplies included in UMP Classic Medicare with Part D (PDP) plan. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 3, Section 6. Medicare approved the UMP Classic Medicare with Part D (PDP) Drug List.

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

We'll post an online copy of the Drug List. The online copy of the Drug List (formulary) is posted monthly and can change throughout the year. To get the most complete and current information about which drugs are covered, visit **ArrayRxSolutions.com/UMP** or call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711).

Section 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* *Please contact PEBB Customer Service for the premium amounts for 2027. (Go to Chapter 2, Section 1 for contact information.)	**Your monthly premium is set by the PEBB Program.**

	Your Costs in 2027
Part D drug coverage (Go to Chapter 4 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Part D drug coverage yearly deductible $100 except for drugs on Tier 1, Tier 2, covered insulin products and most adult Part D vaccines.** **Copayment during the Initial Coverage Stage (30-day supply):** **Drug Tier 1: You pay $0 copay per prescription for each prescription filled.** **Drug Tier 2: You pay up to a $10 copay per prescription for each prescription filled.** **Drug Tier 3: You pay up to a $40 copay per prescription for each prescription filled. You pay $10 per 30-day supply of each covered insulin product on this tier.** **Drug Tier 4: You pay up to a $75 copay per prescription for each prescription filled. You pay $10 per 30-day supply of each covered insulin product on this tier.** **Drug Tier 5: You pay up to a $90 copay per prescription for each prescription filled.** **Drug Tier 6: You pay a $0 copay per prescription for each prescription filled.** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.** **You may have cost sharing for bonus non-Part D prescription drugs and related supplies that are covered under our enhanced benefit or if you fill your prescriptions at a non-network pharmacy.**

Your costs may include the following:

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

Section 4.1 Plan Premium

As a member of our plan, you pay a monthly plan premium.

Your coverage is provided through a contract with the Health Care Authority (HCA). Your monthly premium is set by the PEBB Program. Please contact PEBB Customer Service for the premium amounts or visit **hca.wa.gov/employee-retiree-benefits/retirees/retiree-monthly-premiums**.

In some situations, your plan costs could be less.

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. Learn more about this program in Chapter 2, Section 7. If you qualify and enroll, any Low-Income Subsidy amounts received under Extra Help will be reimbursed to you separately and will not be deducted from your monthly plan premium.

If you *already* get Extra Help, ArrayRx sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711) and ask for the *LIS Rider*.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2027* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website at (**Medicare.gov/medicare-and-you**) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Some members are required to pay other Medicare premiums

You must have either Part A and/or Part B to be enrolled in a Part D plan. Although most people do not have to pay for Part A, some do. If you have to pay for Part A, you must also have Part B. In addition to paying the monthly UMP Classic Medicare with Part D (PDP) plan premium, you must continue paying your Medicare premiums to stay a member of our plan.

Section 4.3 Part D Late Enrollment Penalty

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

When you first enroll in UMP Classic Medicare with Part D (PDP), ArrayRx will let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

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

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

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage.
- Then Medicare determines the amount of the average monthly premium for Medicare prescription drug plans in the nation from the previous year (national base beneficiary premium). For 2027, this average late enrollment premium amount is $41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times $41.33, which equals $5.79. This rounds to $5.80. This amount will be billed to you separately each month by ArrayRx if you have a Part D late enrollment penalty.

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

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

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us**.** Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you won't have another chance to ask for a reconsideration of that late enrollment penalty.

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

ArrayRx will be billing you for your late enrollment penalty if you have one. Please be sure to pay your late enrollment penalty if you have one or you will be disenrolled from the plan.

There are two options for payment to Moda Health Plan, Inc.

Option 1: Paying by check or money order

You may pay your monthly late enrollment penalty directly to us by check or money order. This method is called Direct Pay. If you choose Direct Pay as your late enrollment penalty payment method, ArrayRx will send you a monthly statement. Direct Pay penalty statements are mailed on the 8th of each month with a due date of the 1st of the following month. Please make sure your check or money order is payable to Moda Health Plan, Inc. (not Medicare, CMS, UMP, HCA, PEBB Program, or HHS). Please include your member ID number on your check. Your member ID number can be found on your UMP Classic Medicare with Part D (PDP) prescription drug membership card.

Mail your check or money order to:

Moda Health
Attn: Accounting
P.O. Box 4220
Portland, OR 97208-4220

Drop off your check or money order **in person** at:

Moda Health Plan, Inc.
601 S.W. Second Ave.
Portland, OR 97204

Option 2: Electronic Funds Transfer (EFT) from your checking account

Instead of paying by check or money order, you can have your monthly late enrollment penalty automatically withdrawn from your checking account. This method is called EFT (Electronic Funds Transfer) using the Automated Clearing House (ACH). If you choose EFT for your method to pay your late enrollment penalty, you may call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711) to request an EFT form and instructions be mailed to you. ArrayRx Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. You can also download the form by visiting our website at **ArrayRxSolutions.com/UMP**. Print the EFT form and instructions and mail your form to the address listed on the instructions. Once your EFT takes effect, deductions from your checking account for your late enrollment penalty will occur on the

5th of each month. If the 5th falls on a Saturday, Sunday, or holiday, the withdrawal will occur on the next business day.

If you have questions about your late enrollment penalty statement, please call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711). Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours.

Section 4.4 Income Related Monthly Adjustment Amount

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

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

If you are participating in the Medicare Prescription Payment Plan, each month you'll pay your UMP Classic Medicare with Part D (PDP) plan premium and you'll get a bill from SimplicityRx on behalf of ArrayRx 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 explains more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 7 to make a complaint or appeal.

Section 5 More information about your monthly premium

Section 5.1 How to pay your UMP Classic Medicare with Part D (PDP) plan premium

There are four ways you can pay your plan premium.

Option 1: Pay by check

You can pay your UMP Classic Medicare with Part D (PDP) plan premium by check or money order. Each month you will be sent a statement telling you how much you owe. UMP Classic Medicare with Part D (PDP) plan premiums are due on or before the 15th of each month. Make your checks payable to: **Health Care Authority**

Mail your premium to:

Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Option 2: Electronic Debit Service (EDS) from your bank account

Instead of paying by check or money order, you can have your monthly plan premium automatically withdrawn from your checking or savings account. This method is called EDS (Electronic Debit Service). If you choose EDS for your method to pay your plan premium, you may call PEBB Customer Service at 1-800-200-1004 or visit **hca.wa.gov/employee-retiree-benefits/retirees/paying-benefits** to request an EDS form which includes submission instructions. Until the EDS takes place, which may take up to six to eight weeks, you are responsible for paying your premium with a check (or see the other payment options). Once your EDS takes effect, EDS premium deductions will come directly from your bank account on the 15th of each month. If the 15th falls on a Saturday, Sunday, or a holiday, the withdrawal will occur on the next business day.

Option 3: You can have your premium deducted from your pension

To have the premium deducted from your pension, subscribers would select this option on their enrollment request forms. You may call PEBB Customer Service at 1-800-200-1004 or visit **hca.wa.gov** to find out if this option is available to you.

Option 4: You can pay by cash

You may also pay in cash and deliver to the Health Care Authority lobby receptionist. Lobby hours are Monday through Friday, 8 a.m. to 4 p.m. (Pacific). Please do not mail cash. Please note that the Health Care Authority does not have any cash on hand to issue change, please bring exact payment amount or any overpayment will be applied to the next month's premium payment.

Deliver your premium in cash at:

Health Care Authority (HCA)
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Changing the way you pay your plan premium

You can request to change your payment method in writing at any time. If you decide to change the option by which you pay your UMP Classic Medicare with Part D (PDP) plan premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your UMP Classic Medicare with Part D (PDP) plan premium is paid on time. To change your payment method, please call PEBB Customer Service 1-800-200-1004.

If you have trouble paying your plan premium

Your UMP Classic Medicare with Part D (PDP) plan premium is due in HCA's office by the 15th day of the month. If HCA has not received your UMP Classic Medicare with Part D (PDP) premium and any other required health plan premiums by the time frame indicated in the notice, they will send you another notification telling you that your plan membership will end if they do not receive your premium payment within the time frame indicated.

If you are having trouble paying your UMP Classic Medicare with Part D (PDP) plan premium on time, please contact PEBB Customer Service to see if they can direct you to programs that may help with your plan premium.

If we end your membership because you did not pay your UMP Classic Medicare with Part D (PDP) plan premiums, you'll still have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year when you enroll in a new

plan during the Medicare annual 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 HCA has wrongfully ended your UMP Classic Medicare with Part D (PDP) 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 within the grace period, you can make a complaint. For complaints, HCA will review their decision again. Chapter 7, Section 7 of this document tells how to make a complaint, or you can call PEBB Customer Service at 1-800-200-1004 between 8 a.m. to 4:30 p.m. (Pacific), Monday through Friday. TTY users should call 711. You must make your request no later than 60 calendar days after the date your membership ends.

If the PEBB Program terminates your coverage for nonpayment of premiums, you will be sent a termination notice and will have no later than 60 calendar days from the date of the notice to appeal the termination to the PEBB Appeals Unit.

Section 5.2 Your monthly plan premium won’t change during the year

We’re not allowed to change our plan’s monthly UMP Classic Medicare with Part D (PDP) plan premium amount during the year. If the monthly UMP Classic Medicare with Part D (PDP) plan premium changes for next year, we’ll tell you in October and the new premium will take effect on January 1.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the amount that you are reimbursed from the Extra Help program may change. If you qualify for Extra Help with your drug coverage costs, ArrayRx reimburses you a part of your monthly plan costs via a monthly check. If you lose your eligibility for Extra Help during the year, this reimbursement will stop. Please note that regardless of whether or not you are receiving Extra Help, you must pay the full amount of your UMP Classic Medicare with Part D (PDP) plan premium. Extra Help is a reimbursement of a portion of your costs sent to you, not a direct payment of your premium or drug costs.

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

Section 6 Keep your plan membership record up to date

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

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

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

Contact PEBB Customer Service about these changes:

- Changes to your name, address, or phone number
- If your designated responsible party (such as a caregiver) changes

Contact ArrayRx Customer Service about these changes:

- 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) or PEBB Customer Service at 1-800-200-1004 (TTY users should 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, ArrayRx will send you a letter that lists any other medical or drug coverage we know about (as applicable). 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

ArrayRx Customer Service at 1-833-599-8539 (TTY users should 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 all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

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

- If you have retiree coverage, Medicare pays first.
- 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 UMP Classic Medicare with Part D (PDP) contacts

How to contact the Public Employees Benefits Board (PEBB) Customer Service

For help with UMP Classic Medicare with Part D (PDP) plan premiums, updating your name, address, or phone number, please call or write to PEBB Customer Service. They will be happy to help you.

PEBB Customer Service – Contact Information	
Call	**1-800-200-1004** Calls to this number are free. PEBB Customer Service is available from 8 a.m. to 4:30 p.m. (Pacific), Monday through Friday. PEBB Customer Service also has free language interpreter services for non-English speakers.
TTY	**711** This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking. Calls to this number are free. PEBB Customer Service is available from 8 a.m. to 4:30 p.m. (Pacific), Monday through Friday.
Fax	**1-360-725-0771**
Write	**Health Care Authority (HCA)** **PEBB Program** PO Box 42684 Olympia, WA 98504-2684 Online support: **support.hca.wa.gov/hcasupport**
Website	**hca.wa.gov**

How to contact ArrayRx Customer Service

For help with pharmacy claims, billing, member identification (ID) card questions, or other pharmacy-related questions, please call or write to ArrayRx Customer Service. We will be happy to help you.

ArrayRx Customer Service – Contact Information	
Call	**1-833-599-8539** Calls to this number are free. ArrayRx Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day. ArrayRx Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking. Calls to this number are free. ArrayRx Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours.
Write	**ArrayRx** **Medicare ArrayRx Customer Service** P.O. Box 40327 Portland, OR 97240-0327 Email: **UMPRXMedicare@modahealth.com**
Website	**ArrayRxSolutions.com/UMP**

How to ask for a coverage decision

A coverage decision (also known as a coverage determination) is a decision we make about your coverage or about the amount we pay for your Part D drugs. For more information on how to ask for coverage decisions or appeals about your Part D drugs, go to Chapter 7.

Coverage Decisions for Part D prescription drugs – Contact Information	
Call	**1-833-599-8539** Calls to this number are free. ArrayRx Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day.
TTY	**711** This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking. Calls to this number are free. ArrayRx Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours.
Fax	**1-800-207-8235** **Medicare Pharmacy Coverage Decisions**
Write	**ArrayRx** **Medicare Pharmacy Coverage Decisions** P.O. Box 40327 Portland, OR 97240-0327 Email: **UMPRXMedicare@modahealth.com**

How to ask for an appeal

An appeal (also known as a redetermination) 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.

Appeals for Part D prescription drugs – Contact Information	
Call	**1-833-599-8539** Calls to this number are free. Office hours are 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day. **1-855-466-7211 Expedited Medicare Pharmacy Appeal and Grievance (voicemail only)** This is a voicemail only number that can be used to submit an expedited oral appeal. If you need to submit an expedited oral appeal, please leave your name, phone number, member identification number (if available), and the details of your denial. We will call you back and confirm the details of your case.
TTY	**711** This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking. Calls to this number are free. ArrayRx Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30.
Fax	**1-833-949-1888** **Medicare Pharmacy Appeal and Grievance**
Write	**ArrayRx** **Medicare Pharmacy Appeal and Grievance** PO Box 40384 Portland, OR 97240-0384 Email: **UMPRXMedicare@modahealth.com**

How to make a complaint

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

Complaints – Contact Information	
Call	**1-833-599-8539** Calls to this number are free. Office hours are 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day. **1-855-466-7211 Expedited Medicare Pharmacy Appeal and Grievance (voicemail only)** This is a voicemail only number that can be used to submit an expedited oral complaint. If you need to submit an expedited oral complaint, please leave your name, phone number, member identification number (if available), and the details of your complaint. We will call you back and confirm the details of your case.
TTY	**711** This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking. Calls to this number are free. ArrayRx Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30.
Fax	**1-833-949-1888** **Medicare Pharmacy Complaints**
Write	**ArrayRx** **Medicare Pharmacy Complaints** P.O. Box 40384 Portland, OR 97240-0384 Email: **UMPRXMedicare@modahealth.com**

Complaints – Contact Information	
Medicare website	To submit a complaint about UMP Classic Medicare with Part D (PDP) directly to Medicare, go to **Medicare.gov/MedicareComplaintForm/home**.

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

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

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

Payment Requests – Contact Information	
Call	**1-833-599-8539** Calls to this number are free. Office hours are 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day.
TTY	**711** This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking. Calls to this number are free. ArrayRx Customer Service is available from 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30.
Fax	**1-855-668-8550** **Medicare Pharmacy Claims**
Write	**Manual Claims** **UMP Classic Medicare with Part D (PDP)** P.O. Box 1039 Appleton, WI 54912-1039

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 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 UMP Classic Medicare with Part D (PDP).

Medicare – Contact Information	
Website (cont.)	**To submit a complaint to Medicare,** go to **Medicare.gov/MedicareComplaintForm/home**. 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. You can find a list of the State Health Insurance Assistance Programs in each state we serve in Appendix 4 at the end of this document.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES	
Website	• Visit **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 (QIO) serves people with Medicare in each state. You can find a list of the Quality Improvement Organizations in each state we serve in Appendix 1 at the back of this document.

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

Contact Your state Quality Improvement Organization if you have a complaint about the quality of care you got. For example, you can contact Your state Quality Improvement Organization 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) Program:** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI)**: Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, contact the Medicaid agency in your state. For a list of Medicaid agencies by state, please refer to Appendix 3 at the back of this document.

Section 7 Programs to help people pay for prescription drugs

The Medicare website (**Medicare.gov/basics/costs/help/drug-costs**) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare prescription drug plan's monthly premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs. Extra Help is provided as a check each month from ArrayRx, not as a reduction to your monthly premium, yearly deductible, or copayments.

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.

- Please call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711) to request assistance with obtaining the best available evidence. If you have information from your state of residence or Social Security that specifies your copayment amount, contact ArrayRx Customer Service first and we will note this in our system. Then fax the information to Attn: Medicare ArrayRx Customer Service at 1-800-207-8235. If you are at the pharmacy, your pharmacy can call ArrayRx Customer Service and also fax a copy of your documentation.
- 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) if you have questions.

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

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

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

Refer to Appendix 2 at the back of this document for a list of contact information for State Pharmaceutical Assistance Programs.

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 prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the state specific ADAP. Refer to Appendix 2 at the back of this document for a list of contact information for State Pharmaceutical Assistance Programs.

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 Appendix 2 at the back of this document for a list of contact information for State Pharmaceutical Assistance Programs.

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.

Refer to Appendix 2 at the back of this document for a list of contact information for State Pharmaceutical Assistance Programs.

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 prescription drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this payment option, call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) or visit **Medicare.gov**.

This payment option is not available for drugs that are not covered by UMP Classic Medicare with Part D (PDP) or bonus non-Part D Prescription drugs and related supplies included in the plan formulary.

Medicare Prescription Payment Plan – Contact Information	
Call	**1-833-286-9495** Calls to this number are free. Office hours are 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on holidays), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Office hours are 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on holidays), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking.
Fax	**1-440-557-6525**
Write	UMP Classic Medicare with Part D (PDP) MPPP Support Department 810 Sharon Dr. Westlake, OH 44145 Email: **ElectMPPP@RxPayments.com**
Website	**ArrayRxSolutions.com/UMP**

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, call the employer/union benefits administrator or PEBB Customer Service at 1-800-200-1004 (TTY users should call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers are PEBB Customer Service at 1-800-200-1004 (TTY users should call 711) or ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) and are also printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

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 prescription drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some additional drugs:

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, go to your *Medicare & You 2027* handbook.) Your Part D prescription drugs are covered under our plan.

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 or you can fill your prescription through your plan's mail-order pharmacies).
- 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 pharmacies

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

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

Please note: There are no network pharmacies outside of the United States and its territories, (for a travel exception that would allow a fill of your prescriptions prior to traveling see Chapter 3, Section 4.2).

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (**ArrayRxSolutions.com/UMP**), and/or call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

You may go to any of our network pharmacies.

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, call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) or use the *Pharmacy Directory*. You can also find information on our website at **ArrayRxSolutions.com/UMP.**

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 prescription drugs in an LTC facility, call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* at **ArrayRxSolutions.com/UMP** or call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

Section 2.2 Our plan's mail-order pharmacies

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

Our plan's mail-order pharmacies allow you to order **31 through 90-day supply for most drugs except specialty drugs and vaccines.**

To get order forms and information about filling your prescriptions by mail you can call ArrayRx Customer Service at the number listed on the back of this document. To find a network mail-order pharmacy, you may use the Pharmacy Locator Tool at **ArrayRxSolutions.com/UMP**. If you use a mail-order pharmacy not in the plan's network, your prescription may not be covered.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. If your order is delayed, call ArrayRx Customer Service for assistance (phone numbers are printed on the back cover of this document).

New prescriptions the pharmacy gets directly from your doctor's office.
After the pharmacy gets 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. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills, contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

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

Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* at **ArrayRxSolutions.com/UMP** tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711)** to see if there's a network pharmacy nearby.

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

- Prescriptions related to care for a medical emergency or urgently needed care.
- A network pharmacy that provides 24-hour services is not within a reasonable driving distance.
- You are unable to fill a prescription that is not regularly stocked at an in-network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty drugs).
- Self-administered Part D prescription drugs provided in an outpatient setting (such as a provider clinic).

Note: Prescriptions filled at an out-of-network pharmacy in the situations listed above are limited to a 30-day supply.

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. Please be sure to keep your receipt.

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 and any covered non-Part D prescription drugs and related supplies.

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.

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 6 cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- Tier 1 – Preferred Generic – Lowest cost-sharing tier, includes preferred generic drugs
- Tier 2 – Generic – Tier includes generic drugs
- Tier 3 – Preferred Brand – Tier includes preferred brand drugs
- Tier 4 – Non-Preferred Drug – Tier includes non-preferred drugs
- Tier 5 – Specialty Tier – Highest cost-sharing tier includes specialty drugs
- Tier 6 – Vaccines – Tier includes Part D vaccines, which may have no cost share

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.

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

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

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (**ArrayRxSolutions.com/UMP**). The Drug List on the website is always the most current.
- Call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.

- Use our plan's "Real-Time Benefit Tool" (also called the *Drug Price Estimator*) found at **ArrayRxSolutions.com/UMP** to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

Section 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when 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).

Compounded Medications

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

Generally, compounded medications are non-formulary drugs (not covered) by your plan. Compounded medications may be covered in limited circumstances. To be eligible for Part D prescription drug coverage, all the following requirements must be met:

1. The compounded medication must contain at least one FDA approved drug ingredient and all the active ingredients in the compounded medication and their intended route of administration are clinically supported; and
2. The primary compounded medication ingredient (identified by CMS as the ingredient with the highest cost) must be on the Drug List (formulary); and

3. The compounded medication must be approved by Medicare for the diagnosis or condition for which it's prescribed; and
4. All compounded medication ingredient information must be provided as part of the prescription.

For a coverage determination for a prescribed compounded medication, please contact ArrayRx Customer Service.

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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 7.)

Getting plan approval in advance

For certain prescription 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 prescription drugs. If you don't get this approval, your prescription drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) or on our website **ArrayRxSolutions.com/UMP**.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) or on our website **ArrayRxSolutions.com/UMP**.

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.

Vacation Override policy

Our vacation override policy allows you to obtain an early refill for your prescription(s) prior to traveling outside of the United States (U.S.) and its territories, or if you expect you will run out of your medication(s) while traveling where there are no contracted pharmacies. You are allowed two (2) vacation overrides per plan year. You should contact ArrayRx Customer Service for your vacation override request no more than two (2) weeks prior to travel.

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.

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

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

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask 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're a new member,** we'll cover a temporary supply of your drug during the first **90-days** of your membership in our plan**.**

- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first **90-days** of the calendar year.
- This temporary supply will be for a maximum of 30-days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 30-days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in 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 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.
- Excluded drugs or drugs with specific medical coverage criteria may not be eligible for a temporary supply.

For questions about a temporary supply, call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

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

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask 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 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 check the Drug List (formulary) available at **ArrayRxSolutions.com/UMP** or call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask 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 5.2 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs on our Tier 5 Specialty Tier aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

Section 6 Our Drug List can change during the year

Most 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.

Information on changes to drug coverage

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

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and <u>immediately</u> 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 similar drug (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 a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**

- Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
    - We may make other changes once the year has started that affect drugs you take. For example, we may make a change 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. We will only send notification change letters when there's been a change to the formulary that may negatively affect your access to covered medication. Otherwise, formulary medications can be found on the posted online formulary, by using the Drug Price Estimator tool, or by contacting ArrayRx Customer Service.

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 bonus non-Part D prescription drugs and related supplies 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 prescription 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 prescription drug plans (Our plan covers certain bonus non-Part D prescription drugs and related supplies listed below through our enhanced benefit for which you may have cost sharing. More information is provided in Chapter 4, Section 7.):

- 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. Refer to the Drug List (formulary) for coverage of bonus non-Part D prescription drugs and related supplies included in the plan Drug List (formulary) located at **ArrayRxSolutions.com/UMP**. 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 prescription 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 our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

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

Section 9 Part D drug coverage in special situations

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

If you'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* available at **ArrayRxSolutions.com/UMP** to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

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

Section 9.3 If you are taking drugs covered by Original Medicare

Your enrollment in UMP Classic Medicare with Part D (PDP) doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you're enrolled in our plan. If your drug would be covered by Medicare Part A or Part B, our plan can't cover it.

Some drugs may be covered under Medicare Part B in some situations and through UMP Classic Medicare with Part D (PDP) in other situations. Drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or UMP Classic Medicare with Part D (PDP) for the drug.

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

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

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

Section 9.5 If you also get drug coverage from an employer or 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 your plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

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

Section 9.6 If you're in Medicare-certified hospice

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

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

Section 10 Programs on drug safety and managing medications

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

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you'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 Drug Management Program (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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

Chapter 4:
What you pay for Part D drugs

Section 1 What you pay for Part D drugs

If you are in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert and are enrolled in Extra Help through Medicare, call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D prescription drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some drugs excluded by Medicare may be covered as part of our bonus non-Part D prescription drugs and related supplies enhanced benefit.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3 explains these rules. When you use our plan's "Real-Time Benefit Tool" (also called the "Drug Price Estimator") to look up drug coverage available at **ArrayRxSolutions.com/UMP**, the cost you see shows an estimate of the out-of-pocket costs you're expected to pay and assumes you have met your deductible. You can also get information provided by the "Real-Time Benefit Tool" by calling ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

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

There are 2 different types of out-of-pocket costs for covered Part D prescription drugs at network pharmacies 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.

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 <u>are included</u> 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
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.
- Any payments for your drugs made by family or friends.
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities.

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,400 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>aren't included</u> in your out-of-pocket costs

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

- Your monthly premium.
- Late enrollment penalty.
- Income-Related Monthly Adjustment Amount (IRMAA).
- Drugs you buy outside the United States and its territories.

- Drugs that aren't covered by our plan.
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage (bonus non-Part D prescription drug and related supplies) but not normally covered in a Medicare Prescription 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,400, 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 UMP Classic Medicare with Part D (PDP) members

There are **3 drug payment stages** for your prescription drug coverage under UMP Classic Medicare with Part D (PDP). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Keep in mind you are always responsible for 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 prescription drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

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

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

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

- **Show your 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 (SPAP), 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711). Be sure to keep these reports.

Section 4 The Deductible Stage

The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You'll pay a yearly deductible of $100 on Tier 3, Tier 4 and Tier 5 prescription drugs. **You must pay the full cost of your Tier 3, Tier 4 and Tier 5 prescription drugs** until you reach our plan's deductible amount. For all other drugs you will not have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed

the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay $100 for your Tier 3, Tier 4 and Tier 5 drugs, you leave the Deductible Stage and move on to 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 prescription drugs, and you pay your share (your copayment). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has 6 cost-sharing tiers

Every drug on our plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 – Preferred Generic – Lowest cost sharing tier, includes preferred generic drugs
- Tier 2 – Generic – Tier includes generic drugs
- Tier 3 – Preferred Brand – Tier includes preferred brand drugs
- Tier 4 – Non-Preferred Drug – Tier includes non-preferred drugs
- Tier 5 – Specialty Tier – Highest cost sharing tier, includes specialty drugs
- Tier 6 – Vaccines – Tier includes Part D vaccines, which may have no cost sharing

- On Tiers 3 and 4 you won't pay more than $10 for a 30-day supply of each covered insulin product when utilizing a network pharmacy.

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

Your pharmacy choices

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

- A network retail pharmacy

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

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 3 and our plan's *Pharmacy Directory* available at **ArrayRxSolutions.com/UMP**.

Section 5.2 Your costs for up to a 30-day supply of a covered drug

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

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

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

Your costs for up to a *30-day* supply of a covered Part D drug

Tier	Standard retail cost sharing (in-Network pharmacies) (up to a 30-day supply)	Mail-order cost sharing (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; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$0 copay
Cost-Sharing Tier 2 (Generic)	$10 copay	$10 copay	$10 copay	$10 copay

Tier	Standard retail cost sharing (in-Network pharmacies) (up to a 30-day supply)	Mail-order cost sharing (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; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 3 (Preferred Brand) You won't pay more than $10 for a 30-day supply of each covered insulin product.	$40 copay	$40 copay	$40 copay	$40 copay
Cost-Sharing Tier 4 (Non-Preferred Drug) You won't pay more than $10 for a 30-day supply of each covered insulin product.	$75 copay	$75 copay	$75 copay	$75 copay
Cost-Sharing Tier 5 (Specialty Tier)	$90 copay	$90 copay	$90 copay	$90 copay
Cost-Sharing Tier 6 (Vaccines)	$0 copay	$0 copay	$0 copay	$0 copay

You won't pay more than $10 for a 30-day supply of each covered insulin product when using a network pharmacy regardless of the cost-sharing tier even if you haven't paid your deductible.

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

Section 5.3 If your doctor prescribes less than a 30-day supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a Part D prescription drug covers up to a 30-day supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you plan refill dates better.

If you get less than a 30-day 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 30-day supply. If you get less than a full 30-day supply of a certain drug, you will not have to pay for a full 30-day supply. 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 (31 through 90-day) supply of a covered Part D prescription drug

For some drugs, you can get a long-term supply (also called an *extended supply*). A long-term supply is 31 through 90-day supply.

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 *long-term* (31 through 90-day) supply of a covered Part D drug

Tier	Standard retail cost sharing (in-network pharmacies) 31 through 90-day supply	Mail-order cost sharing 31 through 90-day supply
Cost-Sharing Tier 1 (Preferred Generic)	$0 copay	$0 copay
Cost-Sharing Tier 2 (Generic)	$20 copay	$20 copay
Cost-Sharing Tier 3 (Preferred Brand) You won't pay more than $20 for a 31 through 90-day supply of each covered insulin product	$80 copay	$80 copay
Cost-Sharing Tier 4 (Non-Preferred Drug) You won't pay more than $20 for a 31 through 90-day supply of each covered insulin product.	$150 copay	$150 copay
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5
Cost-Sharing Tier 6 (Vaccines)	A long-term supply is not available for drugs in Tier 6	A long-term supply is not available for drugs in Tier 6

You won't pay more than $20 for up to 31 through 90-day supply of each covered insulin product when using a network pharmacy regardless of the cost-sharing tier, even if you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move to the Catastrophic Coverage Stage.
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. Some payments at out-of-network pharmacies may not apply to 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 $2,400 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 at network pharmacies. You enter the Catastrophic Coverage Stage when your covered out-of-pocket costs reach the $2,400 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.
- For bonus non-Part D prescription drugs and related supplies covered under our enhanced benefit, you pay applicable tiering copays (see cost share charts above).
- You may be responsible for some payments made at out-of-network pharmacies.

Section 7 Additional benefits information

Your UMP Classic Medicare with Part D (PDP) plan covers certain bonus non-Part D prescription drugs and related supplies through our enhanced benefit. While many of the covered non-Part D prescription drugs and related supplies are available for purchase without a prescription, a prescription is required to receive coverage from UMP Classic Medicare with Part D (PDP) for any drug or item included in this enhanced benefit. Additionally, you must generally use network pharmacies. You will use your UMP Classic Medicare with Part D (PDP) prescription drug member ID card at the pharmacy counter for this benefit.

Non-Part D prescription drugs and related supplies are indicated by an asterisk (*) within the formulary available at **ArrayRxSolutions.com/UMP**.

Please note: Your copays for covered non-Part D prescription drugs and related supplies and some payments at out-of-network pharmacies do not count toward your UMP Classic Medicare with Part D (PDP) deductible or out-of-pocket maximum. This means that if you meet your UMP Classic Medicare with Part D (PDP) out-of-pocket maximum, you will still be responsible for these costs. Non-Part D prescription drugs and related supplies that are listed in the Drug List (formulary), indicated by an asterisk (*), are not eligible for reimbursement under the Part D Medicare Prescription Drug Payment Program or the Part D formulary exception process.

Section 8 What you pay for Part D vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you, even if you haven't paid your deductible. Refer to our plan's Drug List or call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) for coverage and cost-sharing details about specific vaccines.

Our plan provides coverage for a number of Part D vaccines. Because coverage for vaccines can be complicated, we suggest that you call ArrayRx Customer Service prior to receiving any vaccinations if you have any concerns.

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. Check with your pharmacy to verify if they offer vaccine services.

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.) Check with your pharmacy to verify if they offer vaccine services.

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

Situation 2: You get the 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 at network providers, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any copayment for the vaccine (including administration) and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

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

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your 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 at network providers, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any copayment for the vaccine administration.

CHAPTER 5:
Asking us to pay our share of the costs for covered drugs

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

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

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

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

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

   Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 3, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

2. **When you pay the full cost for a prescription because you don't have our 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. If a drug is not approved for coverage, you will not be reimbursed for any share of the drug cost.

4. If you're retroactively enrolled in our plan

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

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

When you send us a request for payment, we'll review your request and decide whether the drug should be covered based on plan criteria and coverage rules. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

Section 2 How to ask us to pay you back

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. Your receipts will not be returned so it is a good idea to make a copy of your receipts for your records. **You must submit your claim to us within 60-days** 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 our website available at **ArrayRxSolutions.com/UMP** or call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) and ask for the form.
- Mail your request for payment together with any bills or paid receipts to us at this address:

  Manual Claims
  UMP Classic Medicare with Part D (PDP)
  P.O. Box 1039
  Appleton, WI 54912-1039

  Fax: 1-855-668-8550

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

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

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

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

If you think we 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 information in languages other than English including Spanish and 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, call to file a grievance with the UMP Classic Medicare with Part D (PDP) Medicare Pharmacy Appeal and Grievance Department (see Chapter 2, Section 1). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure 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 prescription 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 prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it'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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

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

As a member of UMP Classic Medicare with Part D (PDP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network pharmacies.** You have the right to get information about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and 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 your state's Department of Health.

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

If you have any problems, 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:

- **Call ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).**
- **Call your local SHIP.** You can find a list of the State Health Insurance Assistance Programs (SHIP) in each state we serve in Appendix 4 at the back of this document.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).**

- **Call your local SHIP.** You can find a list of the State Health Insurance Assistance Programs (SHIP) in each state we serve in Appendix 4 at the back of this document.
- **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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered drugs.
    - Chapters 3 and 4 give details about Part D prescription drug coverage.
- **If you have any other prescription drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you're enrolled in our plan.** Show our plan membership card whenever you get Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions 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 your UMP Classic Medicare with Part D (PDP) plan premium.
    - For most of your drugs covered by our plan, you must pay your share of the cost when you get the drug.
    - You must continue to pay your Medicare premiums (Part A and/or Part B).

  - 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, notify PEBB Customer Service** so they 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.** See Chapter 1, Section 2.2 for information on our service area and your options if you move out of the plan's service area. You will not be able to stay a member of our plan, but you may be able to defer enrollment.
- **If you move, tell Social Security (or the Railroad Retirement Board), also inform PEBB Customer Service so all entities can keep your membership record up to date and know how to contact you.**

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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.
The services of SHIP counselors are free. You can find a list of the State Health Insurance Assistance Programs in each state we serve in Appendix 4 at the back 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**

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 eligible Part D 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.

Please Note: Bonus non-Part D prescription drugs and related supplies indicated by an asterisk (*) in the Drug List (formulary) are not eligible for the Part D formulary exception or appeal process.

Asking for coverage decisions before you get benefits

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

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, due to the coverage requirements in the Part D Drug List (formulary), 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 will 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711).**
- **Get free help** from your State Health Insurance Assistance Program (SHIP).
- **Your doctor or other prescriber can make a request for you.** For Part D prescription 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 ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) and ask for the *Appointment of Representative* form. (The form is also available **CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **ArrayRxSolutions.com/UMP**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

This section is about your Part D drugs only. To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D prescription 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 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

Covering a Part D drug that's not on our Drug List. If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 4 for brand name drugs or Tier 4 for generic drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug List.

1. **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.
2. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of 6 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 an alternative drug(s) for treating your medical condition that is 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 cannot ask us to change the cost-sharing tier for any drug in Tier 5. Tier 5 is a Specialty Tier and we exempt that tier from the exceptions process.
- 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 request. **Fast coverage decisions** are made within **24 hours** after we get your request.

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 website.

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 are available on HCA's website at

ArrayRxSolutions.com/UMP/Drug-Coverage-Determination. Chapter 2 has contact information. You, your representative, or your doctor (or other prescriber) may submit a request for a coverage decision electronically using our secure form. Fill out all required information, attach any supporting documents and submit. 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. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

let you know in writing if your request has been sent to the independent review organization.

- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to 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. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 5.5 How to make a Level 1 appeal

Legal Terms:

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

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

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

A standard appeal decision is usually made within 7 calendar days. A fast appeal decision 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 or call us at 1-833-599-8539.** Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at 1-855-466-7211**. 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 the website at **Hca.wa.gov/assets/pebb/ump-medicare-coverage-redetermination-appeal.pdf .** Include your name, contact information, and information about your claim to help us process your request.
- You, your representative, or your doctor (or other prescriber) may submit a request for an appeal electronically using our secure form. This secure form can be accessed at **ArrayRxSolutions.com/UMP/Drug-Coverage-Redetermination**. Fill out all of the required information, attach any supporting documents, and submit.
- **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 are allowed to charge a reasonable amount for copying and sending this information to you per CMS rules. We will inform you of the costs of copying and mailing the information in your appeal prior to fulfilling your request.

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

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

Deadlines for a fast appeal

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

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

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 5.6 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

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

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

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

Section 5.6 How to make a Level 2 appeal

Legal Term

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

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

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

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review

organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.

- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information we have about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge a reasonable amount for copying and sending this information to you per CMS rules. We will inform you of the costs of copying and mailing the information in your appeal prior to fulfilling your request.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

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

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

For fast appeals:

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

For standard appeals:

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

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

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

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 explains the Level 3, 4, and 5 appeals process.

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

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

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

If the dollar value of the drug you appealed meets certain minimum levels, you may be able to go to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.
For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

If the answer is yes, the appeals process is over. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you 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, the appeals process is over. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.

- **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

If you think the plan has wrongfully ended your UMP Classic Medicare with Part D (PDP) membership, please contact PEBB Customer Service at 1-800-200-1004 between 8 a.m. to 4:30 p.m. (Pacific), Monday through Friday.

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

Section 7.2 How to make a complaint

Legal Terms:

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

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

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

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

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

- **Calling ArrayRx Customer Service at 1-833-599-8539 (TTY users should call 711) is usually the first step.** If there's anything else you need to do, ArrayRx Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- You, or your authorized representative, may file a complaint. You must make the complaint within 60 calendar days from the date of the event or incident that caused you to make a complaint. If you miss the deadline, you may still make the complaint and request an extension of the time frame. Your request may be in writing and include the reason you did not make the complaint on time.

  If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call ArrayRx Customer Service (phone numbers are printed on the back cover of this document) and ask for the Appointment of Representative form. (The form is also available on Medicare's website at **cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf** or on our website at **ArrayRxSolutions.com/UMP**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

  You can mail your complaint to:

  ArrayRx
  Attn: Medicare Appeal and Grievance
  PO Box 40384
  Portland, OR 97240-0384

Deliver in person to:

Moda Health Plan, Inc.
Attn: Medicare Appeal and Grievance
601 S.W. Second Ave., Suite 700
Portland, OR 97204

Or fax your complaint to:

1-833-949-1888
Attn: Medicare Appeal and Grievance

If you call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711), they will record the complaint and repeat back to you the complaint as written, to confirm the accuracy. The complaint will be noted with the time and date. If you mail, fax, or deliver your complaint in person, the receive date and time will be noted on your letter. ArrayRx Customer Service is available from 8 a.m.– 8 p.m. (Pacific), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours.

We have 30 calendar days from the date the complaint was received to make a decision. Sometimes we may need more time to make a decision on your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we find a need for additional information and the delay is in your best interest. If we need more time, you will receive a letter requesting the extra time and explaining why we need more time to make a decision.

If your complaint is regarding quality of care, the letter you receive with the outcome of our decision will include your right to file a quality of care grievance with the Quality Improvement Organization (QIO) in your state.

If we turn down your request for a fast coverage determination, a fast redetermination or a fast appeal and you have not yet received the drug, you have the right to file a fast complaint. Indicate clearly on your request you would like a FAST COMPLAINT REQUEST. You may file a fast complaint by phone (call 1-855-466-7211) or fax as listed above. We will respond to your fast complaint in writing within 24 hours of receipt of your fast complaint.

- 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 UMP Classic Medicare with Part D (PDP) directly to Medicare. To submit a complaint to Medicare, go to **Medicare.gov/MedicareComplaintForm/home**. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:
Ending membership in our plan

Section 1 Ending your membership in our plan

Contact PEBB Customer Service at 1-800-200-1004 for details regarding enrollment and plan change guidelines during the PEBB Program's annual open enrollment or when a special open enrollment event occurs; and for terming and in some cases deferring your enrollment. Ending your membership in UMP Classic Medicare with Part D (PDP) 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 until your coverage ends, and you'll continue to pay your cost share until your membership ends.

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

You can request to end your plan membership at any time. However, if you request disenrollment at a time other than your group's open enrollment periods, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

To stay eligible to return to PEBB health plan coverage at a future date, you may be eligible to end your membership in our plan by deferring PEBB coverage. There are specific reasons a member may be eligible to defer. Please contact PEBB Customer Service at 1-800-200-1004 between 8 a.m. to 4:30 p.m. (Pacific), Monday through Friday, for more information on ending membership in our plan, you can also review Section 3 for more information.

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period for the PEBB Program for plan year 2028 is from October 25, 2027 to November 22, 2027.** If you have any questions or would like more information about when you can end your plan membership, contact PEBB Customer Service at 1-800-200-1004 between 8 a.m. to 4:30 p.m. (Pacific), Monday through Friday.
- **The Open Enrollment Period for Original Medicare** is from **October 15th to December 7th. Please note: This open enrollment period does not apply to the UMP Classic Medicare with Part D (PDP) or any other PEBB Program Medicare plan (see above for the applicable open enrollment period). The Original Medicare open enrollment period is only if you intend to leave the PEBB Program Medicare plan and enroll in a Medicare plan outside of PEBB.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
    - A different PEBB Program Medicare plan. You can end your membership in the UMP Classic Medicare with Part D (PDP) plan by selecting a different PEBB Program Medicare plan during the PEBB Program's annual open enrollment period. The PEBB Program's annual open enrollment period for plan year 2028 is from October 25, 2027 to November 22, 2027. Coverage under your new plan will begin January 1, 2028.
    - Another Medicare prescription drug plan,
    - Original Medicare *with* a separate Medicare prescription drug plan,
    - Original Medicare *without* a separate Medicare prescription 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. Most Medicare health plans also include Part D prescription drug coverage.

If you enroll in most Medicare health plans while enrolled in UMP Classic Medicare with Part D (PDP), you'll be disenrolled from UMP Classic Medicare with Part D (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and a different standalone Part D plan. You cannot keep UMP Classic Medicare with Part D (PDP) for your drug coverage. If you don't want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

Note: If you disenroll from Medicare prescription 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 prescription drug plan later.

- **Your membership will end in our plan** when your new plan's coverage starts on January 1. Make sure the PEBB Program receives your request to end coverage before December 31.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of UMP Classic Medicare with Part D (PDP) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be 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 our plan, call Medicare, or visit the **Medicare.gov:**

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for Medicare prescription 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, please contact ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711).

- **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.

Enrollment time periods vary depending on your situation. Contact PEBB Customer Service at 1-800-200-1004 for details regarding the PEBB Program's special open enrollment events and the changes that can be made.

To find out if you're eligible for a Special Enrollment Period outside of the PEBB Program, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan.
- A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D drug coverage.
    - If you enroll in most Medicare health plans, you'll automatically be disenrolled from UMP Classic Medicare with Part D (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and a different standalone Part D plan. You cannot keep UMP Classic Medicare with Part D (PDP) for your drug coverage. If you don't want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare drug coverage.

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

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

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 prescription 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:

- **Call PEBB Customer Service** at 1-800-200-1004 between 8 a.m. to 4:30 p.m. (Pacific), Monday through Friday.
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048)

Section 3 How to end your membership in our plan

As a member you may have circumstances when you may need to switch plans, defer your enrollment in PEBB retiree insurance coverage, or permanently terminate you or your dependent's enrollment. These changes can be made during the PEBB Program's annual open enrollment period or, if requirements are met, can be made during a special open enrollment event. Termination and deferral requests can be made at any time.

Please note that you must have circumstances that allow for a special open enrollment event to make certain changes, such as changing your medical plan outside of the annual open enrollment period. For example, gaining the eligibility for coverage under Medicare may qualify as a special open enrollment event. For more information in regard to what qualifies you for a special open enrollment period, requirements for making changes during that period, and important deadlines, see:
hca.wa.gov/employee-retiree-benefits/public-employees/what-special-open-enrollment.

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

If you would like:	
To switch to another PEBB plan	• Enroll in a new PEBB Program Medicare plan during the PEBB Program's annual open enrollment period between October 25 and November 22, 2027. The change in enrollment will be effective January 1, 2028. • You may also switch plans if a special open enrollment event occurs. For additional information regarding enrollment, switching plans, required forms, and deadlines, please visit: **hca.wa.gov/employee-retiree-benefits/retirees/change-my-coverage** or • Contact PEBB Customer Service at 1-800-200-1004 for more information. • See below regarding plan deferment or termination information
A Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from UMP Classic Medicare with Part D (PDP) when your new plan's coverage starts.
Original Medicare *with* a different Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. • You'll automatically be disenrolled from UMP Classic Medicare with Part D (PDP) when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare prescription drug plan	• **Send us a written request to disenroll**. Call PEBB Customer Service at 1-800-200-1004 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 UMP Classic Medicare with Part D (PDP) and only have Original Medicare when your coverage in Original Medicare starts.

The table below provides additional information on how you can terminate your membership in the UMP Classic Medicare with Part D (PDP) plan or defer your enrollment.

To terminate your plan or defer your enrollment	
A deferral from PEBB retiree insurance coverage: • An eligible retiree or survivor may request to defer their enrollment in PEBB retiree insurance coverage as an alternative to terminating their PEBB health plan coverage.	• You must be eligible to enroll in PEBB retiree insurance coverage in order to defer your enrollment. • You must have a qualifying reason to defer. • You will also defer your enrollment in dental coverage and if you cover dependents, in most cases, any PEBB health plan coverage they have will be terminated. • To find the qualifying reasons for deferral, what forms are required, how to defer, and deadlines, please visit **hca.wa.gov/employee-retiree-benefits/retirees/defer-coverage**.
• Deferral is a formal process that allows a retiree or survivor to pause or postpone enrollment in PEBB retiree insurance coverage if they have a qualifying reason to defer. Deferring allows them to stay eligible to enroll in the future.	• Submit appropriate forms in one of the following ways: o Online using Benefits 24/7: **benefits247.hca.wa.gov/auth** o Send PEBB Customer Service a secure message: **support.hca.wa.gov/hcasupport** o Fax: 1-360-725-0771 o Mail to: Health Care Authority PEBB Program PO Box 42684 Olympia, WA 98504-2684 If you defer enrollment due to other qualified medical coverage, you must be able to provide proof that you were enrolled continuously in one or more qualifying medical coverages (including start and end dates) during your deferral period to be able to apply for re-enrollment in PEBB retiree health plan coverage.

To terminate your plan or defer your enrollment	
• A retiree or survivor may choose to defer when they are first eligible for PEBB retiree insurance coverage or after they have been enrolled.	If you defer enrollment while enrolled in Medicare and permanently reside outside of the United States or due to a temporary absence from the United States that exceeds the permitted time allowed under the federal regulations and guidance of the Centers for Medicare & Medicaid Services, evidence of continuous enrollment in a qualified coverage is not required while you live outside of the United States. You will be required to provide proof of enrollment in Medicare Part A and Part B, proof of permanent residence in the United States, and proof you currently reside in the United States. For the timelines to re-enroll from deferment, visit **hca.wa.gov/employee-retiree-benefits/retirees/new-retiree-enrollment#enrolling-after-deferring.**
Please note: The PEBB Program may automatically defer your enrollment in PEBB retiree insurance coverage in certain situations. This includes when you are permanently or temporarily residing outside of the service area as described in Section 5.	
To terminate you or your dependent's PEBB coverage: • If you terminate all of your PEBB health plan coverage, you cannot enroll again later unless you regain eligibility.	• If you, the subscriber, terminates your PEBB health plan coverage, in most cases, your dependent's coverage will be terminated as well. • You can terminate your dependent's coverage without terminating your own. • For details such as what forms are required and deadlines, please visit: **hca.wa.gov/employee-retiree-benefits/retirees/change-coverage#cancel-coverage**
For example, you terminated your coverage but then returned to employment with a PEBB or SEBB benefits-eligible position.	• Submit appropriate forms or written requests in one of the following ways: o Online using Benefits 24/7: **benefits247.hca.wa.gov/auth** o Send PEBB Customer Service a secure message: **support.hca.wa.gov/hcasupport** o Fax: 1-360-725-0771 o Mail: Health Care Authority PEBB Program PO Box 42684 Olympia, WA 98504-2684

To terminate your plan or defer your enrollment

Please note: The PEBB Program may terminate you or your dependent's enrollment in PEBB medical when you or your dependent are permanently or temporarily residing outside of the service area as described in Section 5.

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 to get your prescriptions filled.**

Section 5 UMP Classic Medicare with Part D (PDP) must end your plan membership in certain situations

UMP Classic Medicare with Part D (PDP) must end your membership in our plan if any of the following happen:

- If you no longer have either Medicare Part A or Part B.
- If you move out of our service area.
- If you're away from our service area for more than 12 months.

    - If you move or take a long trip, call PEBB Customer Service at 1-800-200-1004 to find out if the place you're moving or traveling to is in our plan's area. If you are no longer in our plan's area, the PEBB Program will terminate or automatically defer your enrollment in our plan.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or national, or an eligible noncitizen.
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that's disruptive and makes it difficult for us to provide care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your 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 don't pay your plan premiums for 2 months.
    - The plan must notify you in writing that you have 2 months to pay the UMP Classic Medicare with Part D (PDP) plan premium before we end your membership.
- 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 prescription drug coverage. See Chapter 1, Section 4.4, Income-Related Monthly Adjustment Amount for more information.
- If you are no longer eligible for this coverage under the PEBB Program.

If you have questions or want more information on when we can end your membership, call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711).

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

UMP Classic Medicare with Part D (PDP) 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 end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you file a grievance or can make a complaint about our decision to end your membership.

CHAPTER 9:
Legal notices

Section 1 Notice about governing law

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

If you have a disability and need help with access to care, call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, ArrayRx Customer Service can help.

Section 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Moda Health, Inc., administrator of ArrayRx, 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 received.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and 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 $2,400 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 bonus non-Part D prescription drugs and related supplies that are covered under our enhanced benefit or for drugs purchased at non-network pharmacies.

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 your deductible.

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 the UMP Classic Medicare with Part D (PDP) 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 6 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

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

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

Customer Service – Departments within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Customer Service is dedicated to providing the highest level of service to customers by providing the information needed to understand your membership and use your plan benefits. This is offered through telephone, email, and written contact. When a non-English speaking caller needs to obtain information, we use a language interpretation service to facilitate the discussion. Chapter 2 has contact information.

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.

Defer – To postpone enrollment or interrupt enrollment in PEBB insurance coverage by a retiree, an eligible survivor, or the PEBB program.

Dependent – A person who meets eligibility requirements in Washington Administrative Code (WAC) 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. The terms "defer" and "terminate" may also be used, see Chapter 8, Section 3.

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.

Health Care Authority (HCA) – is the Washington State agency that administers the Uniform Medical Plan, in addition to the following health care programs: Washington Prescription Drug Program, PEBB Program, SEBB Program, Behavioral Health and Recovery, and Apple Health (also known as Medicaid).

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 and is invoiced monthly. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

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

Lawfully Present – Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare.

Unlawful presence is defined in Section 212(a)(9)(B)(ii) of the Immigration and Nationality Act (INA) to mean that an alien is deemed to be unlawfully present in the U.S. if the alien is (1) present after the expiration of the period of stay authorized by the Secretary of Homeland Security or (2) present without being admitted or paroled.

For most individuals, the period of stay authorized is noted on their I-94 card and they will begin to accrue unlawful presence the day following the date in their I-94 card. Additionally, if the U.S. Citizenship and Immigration Services (USCIS) finds (while adjudicating an application for immigration benefit) that the individual has violated their nonimmigrant status, unlawful presence will begin the day after USCIS denies the benefit (or after the I-94 expires, whichever is earlier).

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

Low-Income Subsidy (LIS) – See definition for Extra Help. Chapter 2 has contact information.

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-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).

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 for Original Medicare – 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. Please note this open enrollment period is used only for plans that are offered outside of the PEBB Program. If you wish to remain in a PEBB Program Medicare plan, please see the Open Enrollment Period for the PEBB Program definition below.

Open Enrollment Period for the PEBB Program – The PEBB Program annual open enrollment period for plan year 2028 is October 25, 2027 to November 22, 2027. This is the period of time defined by HCA when a subscriber may change to another health plan offered by the PEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

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 covered Part D drugs at network pharmacies.

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 ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711).

Part C – Go the definition for to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Prescription 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 prescription drugs by Congress.

Part D Late Enrollment Penalty – An amount invoiced to you monthly 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. Your UMP Classic Medicare with Part D (PDP) premium is paid monthly to the HCA for yourself and any enrolled dependents on your account.

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 our website.

Public Employees Benefits Board (PEBB) – PEBB is a group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

Public Employees Benefits Board (PEBB) Program – The PEBB Program is the HCA program that administers PEBB benefit eligibility and enrollment.

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. This tool is also called the Drug Price Estimator.

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.

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.

Subscriber – The individual who has met the eligibility requirements of this plan and in whose name the coverage is established. Also see definition for Member.

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.

Appendices:

Appendix 1 - Quality Improvement Organization

You may contact the Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) in your state listed below if available at acentraqio.com/or commencehealthqio.cms.gov/en

Please note: The contact information below is listed for your convenience. Due to possible changes with these entities, we cannot guarantee the availability of phone numbers or websites at the time of use. Please refer to the above links as needed.

State	Agency Name, Address and Website	Toll-free Number
Alabama	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Alaska	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-305-6759 Toll-free 844-878-7921 Fax 711 TTY
American Samoa	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	684-699-3330 Toll-free 855-694-2929 Fax 711 TTY
Arizona	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	877-588-1123 Toll-free 855-694-2929 Fax 711 TTY
Arkansas	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
California	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	877-588-1123 Toll-free 855-694-2929 Fax 711 TTY

Connecticut	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
Delaware	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
District of Columbia	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
Florida	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Georgia	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Guam	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	671-685-2689 Toll-free 855-694-2929 Fax 711 TTY
Hawaii	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	877-588-1123 Toll-free 855-694-2929 Fax 711 TTY
Idaho	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-305-6759 Toll-free 844-878-7921 Fax 711 TTY

Illinois	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Indiana	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Iowa	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-755-5580 Toll-free 855-694-2929 Fax 711 TTY
Kansas	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-755-5580 Toll-free 855-694-2929 Fax 711 TTY
Kentucky	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Louisiana	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
Maine	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
Maryland	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY

Massachusetts	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
Michigan	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Minnesota	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Mississippi	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Missouri	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-755-5580 Toll-free 855-694-2929 Fax 711 TTY
Montana	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY
Nebraska	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-755-5580 Toll-free 855-694-2929 Fax 711 TTY
Nevada	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	877-588-1123 Toll-free 855-694-2929 Fax 711 TTY

New Hampshire	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
New Jersey	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	866-815-5440 Toll-free 855-236-2423 Fax 711 TTY
New Mexico	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
New York	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	866-815-5440 Toll-free 855-236-2423 Fax 711 TTY
North Carolina	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
North Dakota	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY
Northern Mariana Islands	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	670-989-2686 Toll-free 855-694-2929 Fax 711 TTY
Ohio	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY

Oklahoma	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
Oregon	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-305-6759 Toll-free 844-878-7921 Fax 711 TTY
Pennsylvania	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
Puerto Rico	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	866-815-5440 Toll-free 855-236-2423 Fax 711 TTY
Rhode Island	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
South Carolina	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
South Dakota	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY
Tennessee	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY

Texas	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
Utah	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY
Vermont	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
Virgin Islands	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	866-815-5440 Toll-free 855-236-2423 Fax 711 TTY
Virginia	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
Washington	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-305-6759 Toll-free 844-878-7921 Fax 711 TTY
West Virginia	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
Wisconsin	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov/en	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Wyoming	Acentra Health BFCC-QIO 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 acentraqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY

Appendix 2 – State Pharmaceutical Assistance Program (SPAP)

You can contact the SPAP in your state listed below if available. Not all states offer a SPAP. The list is also available online at: medicare.gov/plan-compare/#/pharmaceutical-assistance-program/states?year=2026&lang=en

State	Phone	Agency Name, Address and Website
Alabama	334-206-5364	Office of HIV Prevention and Care Alabama Department of Public Health The RSA Tower, Suite 1200 201 Monroe Street Montgomery, Alabama 36104 alabamapublichealth.gov/hiv/
Alaska	907-263-2050	Alaskan AIDS Assistance Association 1057 W. Fireweed Lane, Suite 102 Anchorage, AK 99503 alaskanaids.org/
Arizona	602-542-1025	Arizona Department of Health Services 150 North 18th Avenue Phoenix, Arizona 85007 azdhs.gov/preparedness/bureau-of-infectious-disease-and-services/hiv-hepatitis-c-services/?index.php#aids-drug-assistance-program-home
Arkansas	800-462-0599	Arkansas Department of Health Ryan White Program 4815 West Markham Little Rock, AR 72205-3867 healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/ryan-white-program/
California	916-449-5900	California State Department of Public Health Office of AIDS MS 7700 P.O. Box 997426 Sacramento, CA 95899-7426 cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx#
Colorado	303-692-2000	Colorado Department of Public Health & Environment State Drug Assistance Program (SDAP) 4300 Cherry Creek Drive South Denver, CO 80246 cdphe.colorado.gov/state-drug-assistance-program

Connecticut	800-424-3310	Connecticut Department of Public Health C/O Prime Therapeutics Management PO Box 13001 Albany, NY 12212-3001 ctdph.primetherapeutics.com/
Delaware	844-245-9580	Delaware Prescription Assistance Program PO Box 950 New Castle, DE 19720-0950 dhss.delaware.gov/dmma/dpap/
District of Columbia	202-671-4815	District of Columbia ADAP 2201 Shannon Place SE Washington, DC 20020 dchealth.dc.gov/Pharmacy_Benefits_Program
Florida	850-245-4444	AIDS Drug Assistance Program 4052 Bald Cypress Way Tallahassee FL 32399 floridahealth.gov/individual-family-health/injury-prevention-wellness/hiv-aids/hiv-aids-management/
Georgia	404-657-2700	Georgia AIDS Drug Assistance Program (ADAP) Department of Public Health 200 Piedmont Avenue, SE Atlanta, Georgia 30334 dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap
Hawaii	808-733-4383	Hawai'i State Department of Health HIV Drug Assistance Program (HDAP) 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816 health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/
Idaho	208-985-3019	Idaho Department of Health and Welfare AIDS Drug Assistance Program (ID ADAP) 1720 Westgate Drive Boise, ID 83704 healthandwelfare.idaho.gov/

Illinois	800-243-2437	Illinois Department of Public Health Ryan White Part B Program 525 West Jefferson Street, First Floor Springfield, IL 62761 dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids
Indiana	866-267-4679	HoosierRx 402 W Washington, Rm. 372 Indianapolis, IN 46204 in.gov/medicaid/members/member-programs/hoosierrx/
	866-588-4948	Indiana Department of Health HIV Services Program ADAP 2 N. Meridian St. Indianapolis, IN 46204 in.gov/health/hiv-std-viral-hepatitis/hiv-services/
Iowa	800-972-2017	Iowa Health and Human Services Bureau of HIV STI and Hepatitis 321 E. 12th Street Des Moines, IA 50319 hhs.iowa.gov/health-prevention/hiv-sti-and-hepatitis/hivaids-program
Kansas	785-213-6721	Kansas Department of Health and Environment Ryan White Part B Program 1000 SW Jackson, Suite 210 Topeka, KS 66612 kdhe.ks.gov/355/Ryan-White-Part-B-Program
Kentucky	800-420-7431	Kentucky AIDS Drug Assistance Program (KADAP) 275 E Main St, HS2E-C Frankfort, KY 40621 chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

Louisiana	504-568-7474	Louisiana Health Access Program 1450 Poydras St, Suite 2136 New Orleans, LA 70112 lahap.org/
	800-992-4379	Louisiana Department of Health SHHP Program PO Box 629 Baton Rouge, LA 70821-0629 ldh.la.gov/page/shhp
Maine	207-287-3747	Department of Health and Human Services Ryan White Part B Program 40 State House Station Augusta, ME 04330-9758 maine.gov/dhhs/mecdc/diseases-conditions/sexually-transmitted-diseases/hiv-aids/ryan-white
Maryland	800-551-5995	Maryland Senior Prescription Drug Program c/o International Software Systems Inc. PO Box 749 Greenbelt, Maryland 20768-0749 marylandspdap.com/
	800-205-6308	Maryland AIDS Drug Assistance Program (MADAP) 201 W Preston Street Baltimore, MD 21201 health.maryland.gov/phpa/IDPHSB/Pages/MADAP.aspx
Massachusetts	800-243-4636	Prescription Advantage P.O. Box 15153 Worcester, MA 01615-0153 prescriptionadvantagema.org/
Michigan	888-826-6565	Michigan Drug Assistance Program P.O. Box 30727 Lansing, MI 48909 michigan.gov/dap

Minnesota	800-657-3761	Minnesota Department of Human Services AIDS Drug Assistance Program (ADAP) P.O. Box 64972 St. Paul, MN 55164-0972 mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp
Mississippi	888-458-4948	Mississippi State Department of Health Ryan White Part B Care and Treatment Division PO Box 1700 Jackson, MS 39215-1700 msdh.ms.gov/page/14,13047,150.html
Missouri	573-751-6400	Missouri Department of Health & Senior Services PO Box 570 Jefferson City, MO 65102 health.mo.gov/
Montana	406-444-3565	Montana Ryan White HIV Treatment Program PO Box 4210 Helena, MT 59604-4210 dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog
Nebraska	800-922-0000	Nebraska Medicine Ryan White HIV/AIDS Program 987400 Nebraska Medical Center Omaha, NE 68198-7400 nebraskamed.com/hiv/ryan-white-assistance

Nevada	888-311-7632	Nevada Medication Assistant Program (NMAP) Ramsell Corporation 2300 Clayton Road, Suite 1490 Concord, CA 94520 ramsellcorp.com/pharmacies/nv.aspx
New Hampshire	603-271-4502	New Hampshire AIDS Drug Assistance Program (ADAP) 29 Hazen Drive Concord, NH 03301 dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-aids
New Jersey	800-613-4533	NJ AIDS Drug Distribution program (NJADDP) P. O. Box 360 Trenton, NJ 08625-0360 nj.gov/health/hivstdtb/hiv-aids/medications.shtml
	800-792-9745	NJ Pharmaceutical Assistance to the Aged & Disabled (NJADDP) P.O. Box 715 Trenton, NJ 08625-0715 nj.gov/humanservices/doas/services/l-p/paad/
	800-792-9745	NJ Senior Gold Discount card program P.O. Box 715 Trenton, NJ 08625-0715 nj.gov/humanservices/doas/services/q-z/senior-gold/
New Mexico	866-306-1882	New Mexico Medical Insurance Pool P.O. 780548 San Antonio, TX 78278 nmmip.org/
New York	800-332-3742	New York State Department of Health EPIC Program PO Box 15018 Albany, NY 12212-5018 health.ny.gov/health_care/epic/

New York (continued)	800-542-2437	New York State Department of Health Uninsured Care Programs Empire Station P.O. Box 2052 Albany, NY 12220-0052 health.ny.gov/diseases/aids/general/resources/adap/index.htm
North Carolina	919-733-3419	North Carolina HIV Medication Assistance Program (NC HMAP) 1902 Mail Service Center Raleigh NC 27699-1902 epi.dph.ncdhhs.gov/cd/hiv/hmap.html
North Dakota	701-328-2310	North Dakota Health & Human Services ND Ryan White Program 600 East Boulevard Ave, Dept 325 Bismarck, ND 58505-0250 hhs.nd.gov/health/diseases-conditions-and-immunization/HIV/LivingwithHIV/RyanWhite
Ohio	800-777-4775	Ohio HIV Drug Assistance Program 246 N High Street Columbus, OH 43215 odh.ohio.gov/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/welcome-to
Oklahoma	405-271-4636	Oklahoma AIDS Drug Assistance Program 1000 NE Tenth & Stonewall Mail Drop 0308 Oklahoma City, OK 73117-1299 rxresource.org/prescription-assistance/oklahoma-aids-drug-assistance-program.html
Oregon	971-673-0144	CAREAssist Program 800 NE Oregon Street, Suite 1105 Portland, OR 97232 oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/CAREASSIST/Pages/index.aspx

Pennsylvania	800-225-7223	Pennsylvania Department of Health Chronic Renal Disease Program (CRDP) 625 Forster St. 7th Floor East Wing Harrisburg, PA 17120-0701 pa.gov/agencies/health/diseases-conditions/chronic-disease/chronic-renal-disease.html
	877-356-5355	Special Pharmaceutical Benefits Program - Mental Health P.O. Box 2675 Harrisburg, PA 17105-2675 pa.gov/agencies/dhs/resources/pharmacy-services/special-pharmaceuticals
	800-225-7223	PACE/PACENET PO Box 8806 Harrisburg, PA 17105-8806 pacecares.primetherapeutics.com/
	800-922-9384	Department of Health Special Pharmaceutical Benefits Program/ADAP P.O. Box 8808 Harrisburg, PA 17105-8808 health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx
Puerto Rico	787-765-2929	Departamento de Salud Programa Ryan White Parte B/ADAP PO Box 70184 San Juan, PR 00936-8184 salud.pr.gov/CMS/137
Rhode Island	401-462-0560	Rhode Island Pharmaceutical Assistance to Elders (RIPAE) 25 Howard Ave, Building 57 Cranston, RI 02920 oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance
South Carolina	800-856-9954	South Carolina AIDS Drug Assistance Program (SC ADAP) 400 Otarre Parkway Cayce, SC 29033 dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program

South Dakota	605-367-5182	Ryan White Part B CARE Program South Dakota Department of Health 1501 S. Highline Ave., Suite 3D Sioux Falls, SD 57110 doh.sd.gov/topics/diseases/disease-prevention-services/hivaids/ryan-white-part-b-program/
Tennessee	615-741-7500	Tennessee Department of Health Ryan White Part B Program 710 James Robertson Parkway Nashville, TN 37243 tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html
Texas	800-222-3986	Texas Kidney Health Care Program Mail Code 1938 P.O. Box 149030 Austin, TX 78714-9947 hhs.texas.gov/services/health/kidney-health-care
	800-255-1090	Texas State Pharmacy Assistance Program (SPAP) P.O. Box 149347 Austin, TX 78714-9347 dshs.texas.gov/hivstd/meds/spap
Utah	801-538-6191	Utah Department of Health & Human Services Ryan White HIV/AIDS Program Cannon Health Building 288 N 1460 W Salt Lake City, Utah 84116 epi.utah.gov/ryan-white/

Vermont	800-464-4343	Vermont Medication Assistance Program (VMAP) 280 State Drive Waterbury, VT 05671-8300 healthvermont.gov/disease-control/hiv/hiv-care
Virgin Islands	340-774-3168	Community Health, Roy Lester Schneider Regional Medical Center, 9048 Alton Adams Sr Dr St. Thomas, VI 00802 doh.vi.gov/programs/communicable-diseases/
Virginia	800-533-4148	Virginia Medication Assistance Program (VA MAP) P.O. Box 2448 Richmond, Virginia 23218-2448 vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/
Washington	877-376-9316	Early Intervention Program (EIP) PO Box 47841 Olympia, WA 98504-7841 doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services
Washington DC	202-671-4815	DC Health DC AIDS Drug Assistance Program 2201 Shannon Place SE Washington, DC 20020 dchealth.dc.gov/Pharmacy_Benefits_Program
West Virginia	304-232-6822	West Virginia Health & Human Resources Ryan White Part B Program PO Box 6360 Wheeling, WV 26003 oeps.wv.gov/rwp/pages/default.aspx

Wisconsin	800-657-2038	Wisconsin Department of Health Services SeniorCare: Prescription Drug Assistance Program PO Box 6710 Madison, WI 53716-0710 dhs.wisconsin.gov/seniorcare/index.htm
	608-266-1865	Wisconsin HIV Drug Assistance Program (HDAP) 201 E. Washington Ave. Madison, WI 53703 dhs.wisconsin.gov/hiv/hdap.htm
Wyoming	866-571-0944	Wyoming Department of Health Communicable Disease Treatment Program 2300 Capitol Ave Cheyenne, WY 82002 health.wyo.gov/publichealth/communicable-disease-unit/hiv/

Appendix 3 –State Medicaid Agencies

You may contact the State Medicaid Agencies in your state listed below if available. The list is also available online at: medicaid.gov/about-us/where-can-people-get-help-medicaid-chip#statemenu

State	Agency Name and Website	Toll-free Number
Alabama	Alabama Medicaid medicaid.alabama.gov/	800-362-1504
Alaska	Alaska Department of Health health.alaska.gov/en/services/division-of-public-assistance-dpa-services/apply-for-medicaid/	800-478-7778
American Samoa	American Samoa Medicaid State Agency medicaid.gov/state-overviews/american-samoa.html	877-267-2323
Arizona	Arizona Health Care Cost Containment System (AHCCCS) azahcccs.gov/	800-654-8713
Arkansas	Arkansas Department of Human Services humanservices.arkansas.gov/	855-372-1084
California	Department of Health Care Services dhcs.ca.gov/	800-541-5555
Colorado	Health First Colorado healthfirstcolorado.com/	800-221-3943
Connecticut	Connecticut Medicaid huskyhealthct.org/members/contact_us.html	855-805-4325
Delaware	Delaware Medicaid & Medical Assistance dhss.delaware.gov/dmma/	866-843-7212
District of Columbia	DC Medicaid districtdirect.dc.gov/ua/	202-727-5355
Florida	Florida Agency for Health Care Administration ahca.myflorida.com/medicaid/recipient-resourcess	877-254-1055
Georgia	Georgia Medicaid dch.georgia.gov/	404-656-4507
Guam	Department of Public Health and Social Services opa.hhs.gov/grant-programs/title-x-service-grants/current-title-x-service-grantees/guam-department-public	671-300-7330
Hawaii	Hawaii Med QUEST Division medquest.hawaii.gov/en/about/what-is-medicaid.html	800-316-8005
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) healthandwelfare.idaho.gov/contact-us	877-456-1233

Illinois	Illinois Department of Healthcare and Family Services hfs.illinois.gov/	800-843-6154
Indiana	Indiana Family and Social Services Administration in.gov/fssa/dfr/medicaid-health-plans/	800-457-8283
Iowa	Iowa Department of Human Services hhs.iowa.gov/medicaid/services-care	800-972-2017
Kansas	KanCare kancare.ks.gov/	800-792-4884
Kentucky	Kentucky Cabinet for Health and Family Services chfs.ky.gov/agencies/dms/member/Pages/default.aspx	855-459-6328
Louisiana	Healthy Louisiana ldh.la.gov/microsite/48	888-342-6207
Maine	Maine Department of Health and Human Services maine.gov/dhhs/ofi/programs-services/health-care-assistance	855-797-4357
Maryland	Maryland Department of Health health.maryland.gov/mmcp/Pages/home.aspxx	877-463-3464
Massachusetts	MassHealth mass.gov/orgs/masshealth	800-841-2900
Michigan	Michigan Department of Health & Human Services michigan.gov/mdhhs/assistance-programs/medicaid	800-642-3195
Minnesota	Minnesota Department of Human Services mn.gov/dhs/	800-366-5411
Mississippi	Mississippi Division of Medicaid medicaid.ms.gov/	800-421-2408
Missouri	Missouri Department of Social Services dss.mo.gov/	573-751-3425
Montana	Montana Department of Public Health & Human Services dphhs.mt.gov/MontanaHealthcarePrograms/	800-362-8312
Nebraska	Nebraska Department of Health and Human Services dhhs.ne.gov/Pages/default.aspx	855-632-7633
Nevada	Nevada Department of Health and Human Services dhs.nv.gov/	775-684-4000
New Hampshire	New Hampshire Department of Health and Human Services dhhs.nh.gov/	844-275-3447

New Jersey	New Jersey Department of Human Services nj.gov/humanservices/	800-701-0710
New Mexico	New Mexico Human Services Department hca.nm.gov/	800-283-4465
New York	New York State Department of Health health.ny.gov/health_care/medicaid/	800-541-2831
North Carolina	North Carolina Medicaid medicaid.ncdhhs.gov/	888-245-0179
North Dakota	North Dakota Department of Human Services hhs.nd.gov/applyforhelp	800-366-6888
Northern Mariana Islands	Commonwealth Medicaid Agency cnmimedicaid.org/	670-664-4880
Ohio	Ohio Department of Medicaid medicaid.ohio.gov/	800-324-8680
Oklahoma	Oklahoma Health Care Authority oklahoma.gov/ohca.html	800-987-7767
Oregon	Oregon Health Care healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania	Pennsylvania Department of Human Services pa.gov/agencies/dhs	800-692-7462
Puerto Rico	Medicaid Program medicaid.pr.gov/	787-641-4224
Rhode Island	Rhode Island Executive Office of Health and Human Services eohhs.ri.gov/	855-840-4774
South Carolina	South Carolina Health Connections Medicaid scdhhs.gov/	888-549-0820
South Dakota	South Dakota Department of Social Services dss.sd.gov/medicaid/	800-597-1603
Tennessee	TennCare Medicaid tn.gov/tenncare/members-applicants/eligibility/tenncare-medicaid.html	800-342-3145
Texas	Texas Health and Human Services hhs.texas.gov/services/health/medicaid-chip	800-335-8957
Utah	Utah Department of Health Medicaid medicaid.utah.gov/	866-435-7414
U. S. Virgin Islands	Virgin Islands DHS dhs.vi.gov/	340-774-0930
Vermont	Department of Vermont Health Access dvha.vermont.gov/	855-899-9600

Virginia	Virginia Department of Medical Assistance Services dmas.virginia.gov/#/index	800-643-2273
Washington	Washington Stage Health Care Authority hca.wa.gov/	800-562-3022
West Virginia	West Virginia Department of Human Resources, Bureau of Medical Services bms.wv.gov/members	304-558-1700
Wisconsin	Wisconsin Department of Health Services dhs.wisconsin.gov/	888-786-3246
Wyoming	Wyoming Department of Health health.wyo.gov/	855-294-2127

Appendix 4 –State Health Insurance Assistance Programs (SHIP)

You may contact the SHIP in your state listed below if available. The list is also available online at: shiphelp.org

State	Agency Name and Website	Toll-free Number
Alabama	State Health Insurance Assistance Program (SHIP) alabamaageline.gov/	800-243-5463
Alaska	Alaska Medicare Information Office (SHIP) health.alaska.gov/en/senior-and-disabilities-services/medicare-office/	800-478-6065
Arizona	Arizona State Health Insurance Assistance Program (SHIP) azship.org/	800-432-4040
Arkansas	Senior Health Insurance Information Program (SHIIP) insurance.arkansas.gov/consumer-services/senior-health/	800-224-6330
California	California Health Insurance Counseling and Advocacy Program (HICAP) aging.ca.gov/Programs_and_Services/Medicare_Counseling/	800-434-0222
Colorado	Senior Health Insurance Assistance Program (SHIP) doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare	888-696-7213
Connecticut	Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES) portal.ct.gov/ads/programs-and-services/choices?language=en_US	800-994-9422
Delaware	Delaware Medicare Assistance Bureau insurance.delaware.gov/	800-336-9500
District of Columbia	Health Insurance Counseling Project (HICP) dacl.dc.gov/	202-724-5626
Florida	Serving Health Insurance Needs of Elders (SHINE) floridashine.org/	800-963-5337
Georgia	Georgia State Health Insurance Assistance Program aging.georgia.gov/georgia-ship	866-552-4464
Guam	Guam Medicare Assistance Program (GUAM MAP) cms.gov/contacts/guam-medicare-assistance-program-guam-map/general-beneficiary-contact/1562046	671-735-7415
Hawaii	Hawaii State Health Insurance Assistance Program (SHIP) hawaiiship.org/	888-586-7299

Idaho	Senior Health Insurance Benefits Advisors (SHIBA) doi.idaho.gov/SHIBA/	800-247-4422
Illinois	Senior Health Insurance Program (SHIP) ilaging.illinois.gov/ship.html	800-252-8966
Indiana	State Health Insurance Assistance Program (SHIP) in.gov/ship/	800-452-4800
Iowa	Senior Health Insurance Information Program (SHIP) shiip.iowa.gov/	800-351-4664
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick	800-860-5260
Kentucky	State Health Insurance Assistance Program (SHIP) chfs.ky.gov/agencies/dail/Pages/ship.aspx	877-293-7447
Louisiana	Senior Health Insurance Information Program (SHIIP) ldi.la.gov/consumers/senior-health-shiip	800-259-5300
Maine	Maine State Health Insurance Assistance Program (SHIP) maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	877-353-3771
Maryland	State Health Insurance Assistance Program (SHIP) aging.maryland.gov/Pages/state-health-insurance-program.aspx	410-767-1100
Massachusetts	Serving Health Insurance Needs of Everyone (SHINE) mass.gov/info-details/serving-the-health-insurance-needs-of-everyone-shine-program	800-243-4636
Michigan	Michigan Medicare Assistance Program (MMAP Inc.) michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program	800-803-7174
Minnesota	Minnesota Senior LinkAge Line mn.gov/aging-pathways/	800-333-2433
Mississippi	State Health Insurance Assistance Program (SHIP) mdhs.ms.gov/aging/finding-services-for-older-adults/	844-822-4622
Missouri	Missouri State Health Insurance Assistance Program (SHIP) missouriship.org/	800-390-3330

Montana	Montana State Health Insurance Assistance Program (SHIP) dphhs.mt.gov/sltc/aging/ship	800-551-3191
Nebraska	Nebraska SHIP doi.nebraska.gov/nebraska-ship-smp	800-234-7119
Nevada	Nevada Medicare Assistance Program (MAP) nevadacareconnection.org/care-options/types-of-services/medicare-assistance-program-map/	800-307-4444
New Hampshire	New Hampshire State Health Insurance Assistance Program (SHIP) - ServiceLink Resource Center dhhs.nh.gov/programs-services/adult-aging-care/aging-and-disability-resource-centers	866-634-9412
New Jersey	State Health Insurance Assistance Program (SHIP) nj.gov/humanservices/doas/services/q-z/ship/	800-792-8820
New Mexico	New Mexico ADRC - State Health Insurance Assistance Program (SHIP) aging.nm.gov/services/senior-services	800-432-2080
New York	Health Insurance Information, Counseling and Assistance (HIICAP) aging.ny.gov/health-insurance-information-counseling-and-assistance-programs	800-701-0501
North Carolina	Seniors Health Insurance Information Program (SHIIP) ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip	855-408-1212
North Dakota	State Health Insurance Counseling Program (SHIC) insurance.nd.gov/consumers/medicare	888-575-6611
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP) insurance.ohio.gov/about-us/divisions/oshiip	800-686-1578
Oklahoma	Senior Health Insurance Counseling Program (SHIP) oid.ok.gov/consumers/information-for-seniors/	800-763-2828
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) shiba.oregon.gov/Pages/index.aspx	800-722-4134
Pennsylvania	PA MEDI - Pennsylvania Medicare Education and Decision Insight pa.gov/agencies/aging	800-783-7067
Puerto Rico	State Health Insurance Assistance Program (SHIP) oppea.pr.gov/programas-y-servicios	877-725-4300
Rhode Island	Senior Health Insurance Program (SHIP) oha.ri.gov/Medicare	888-884-8721

South Carolina	State Health Insurance Assistance Program (SHIP) aging.sc.gov/	800-868-9095
South Dakota	Senior Health Information and Insurance Education (SHIINE) dhs.sd.gov/en/ltss/shiine	888-854-5321
Tennessee	Tennessee State Health Insurance Assistance Program (TN SHIP) tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html	800-535-9725
Texas	Health Information, Counseling, and Advocacy Program (HICAP) hhs.texas.gov/services/health/medicare	800-252-9240
Utah	Senior Health Insurance Information Program (SHIP) daas.utah.gov/seniors/	800-541-7735
Vermont	State Health Insurance Assistance Program (SHIP) asd.vermont.gov/services/ship	800-642-5119
Virgin Islands	State Health Insurance Assistance Program (SHIP) ltg.gov.vi/departments/vi-ship-medicare/	340-773-6449
Virginia	Virginia Insurance Counseling & Assistance Program (VICAP) dars.virginia.gov/aging/home-community/medicare-counseling/	800-552-3402
Washington	Statewide Health Insurance Benefits Advisors (SHIBA) insurance.wa.gov/insurance-resources/medicare	800-562-6900
West Virginia	State Health Insurance Assistance Program (SHIP) wvship.org/	877-987-4463
Wisconsin	State Health Insurance Assistance Program (SHIP) dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm	800-242-1060
Wyoming	State Health Insurance Assistance Program (SHIP) wyomingseniors.com/services/wyoming-state-health-insurance-information-program	800-856-4398

ArrayRx Customer Service – Contact Information	
Call	**1-833-599-8539** Calls to this number are free. Office hours are 8 a.m. – 8 p.m. (Pacific), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours. ArrayRx Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. This number is available 24 hours a day, seven days a week.
Write	**ArrayRx** Attn: Medicare ArrayRx Customer Service P.O. Box 40327 Portland, OR 97240-0327 Email: **UMPRXMedicare@modahealth.com**
Fax	**1-800-207-8235** Attn: Medicare ArrayRx Customer Service
Website	**ArrayRxSolutions.com/UMP**

Public Employees Benefits Board (PEBB) Customer Service – Contact Information	
Call	**1-800-200-1004** Calls to this number are free. PEBB Customer Service is available from 8 a.m. to 4:30 p.m. (Pacific), Monday through Friday.
TTY	**711** Calls to this number are free. This number is available 24 hours a day, seven days a week.
Write	**Health Care Authority (HCA)** **PEBB Program** PO Box 42684 Olympia, WA 98504-2684 Online Support: **support.hca.wa.gov/hcasupport**
Fax	**1-360-725-0771** Attn: PEBB Customer Service
Website	**hca.wa.gov**

State Health Insurance Assistance Programs – Contact Information
State Health Insurance Assistance Programs are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare. See Appendix 4 in the back of this book for a list of State Health Insurance Assistance Programs.



PO Box 40327 | Portland, OR 97240-0327

Important UMP Classic Medicare with Part D (PDP) Information