 

**MISSOURI DEPARTMENT OF TRANSPORTATION AND**

**MISSOURI STATE HIGHWAY PATROL MEDICAL AND LIFE INSURANCE PLAN**

# SUPPLEMENT TO THE PLAN DOCUMENT FOR THE

**MEDICARE APPROVED PRESCRIPTION DRUG PLAN**

January 1, 2022

<https://www.modot.org/medicare>

**Missouri Department of Transportation & Missouri State Highway Patrol**

**MEDICAL AND LIFE INSURANCE PLAN**

|  |  |  |
| --- | --- | --- |
| 105 West Capitol P O Box 270Jefferson City, MO 65102 | *Toll Free**Voice Fax* | 877-863-9406573-526-0138573-522-1482 |

Subject: Supplement to the Plan Document for the Medicare Approved Prescription Drug Plan

*Dear MoDOT/MSHP Medicare Part D Prescription Drug Program Participant(s****):***

### The enclosed “Supplement to the Plan Document for the Medicare Approved Prescription Drug Plan” provides you with updates regarding the Medicare standard processes. This is an update to inform you of Medicare processes only. At this time, no changes are being made to your MoDOT/MSHP benefit plan design. Each year Medicare does make updates to Part D and in order to be aware of these it is important that you read all Plan materials we send you and make available to you in our website.

Please help us keep your membership record up-to-date by contacting Employee Benefits right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, contact the Employee~~s~~ Benefit’s staff if you answer can answer “YES” to question #1 below from the following Coordination of Benefit survey question:

1. Do you have other benefits that provide coverage for prescription drugs (i.e. Medigap, other employer coverage, etc.)?
2. If yes, please provide the following from your ID card:
	1. Name of the group providing coverage
	2. Type of coverage
	3. Group #
	4. RxBIN
	5. Member ID
	6. Effective date of coverage

If you have any questions, please feel free to contact the Employee Benefits staff at 1-877-863-9406.

Sincerely,



Ashley Halford

Assistant to the Chief Administrative Officer

# Missouri Department of Transportation (MoDOT) and Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan (sponsored by the Missouri Highways and Transportation Commission) with a Medicare Approved Prescription Drug Plan

**Supplement to the Plan Document for Medicare Beneficiaries**

January 1 – December 31, 2022

This document is the supplement to the Evidence of Coverage (EOC) that gives the details about the Medicare Prescription Drug Plan. The EOC and other Plan documents can be found at our website: [**https://www.modot.org/medicare**](https://www.modot.org/medicare). You can also contact the Employee Benefits staff at 1-877-863-9406 and request a copy of the EOC and/or any other document to be mailed or emailed to you.

## This document is also available on the MoDOT/MSHP Employee Benefits website: <https://www.modot.org/medicare>.

**MoDOT/MSHP is a Medicare Prescription Drug Plan. Throughout the remainder of this Supplement to the Evidence of Coverage, we refer to MoDOT/MSHP as “Plan.”**

**Useful Benefit Contact Information: For Prescription Drug Questions:**

**MedImpact 24 hours a day 7 days a week Employee Benefits: 1-844-513-6006**

**TYY: 711**

**For information regarding the MoDOT/MSHP Medicare Prescription Drug Plan, contact Employee Benefits or the insurance representative at your district, division or troop assignment as follows:**

**Employee Benefits Contacts -**

Toll-free ...........................................................................1-877-863-9406

Benefits Specialist..............................................................(573) 526-5173

Benefits Specialist..............................................................(573) 526-0138

Benefits Specialist..............................................................(573) 522-8121

MoDOT Districts: Contact your district insurance representative.

Northwest District-St. Joseph .............................................(816) 387-2405

Northeast District-Hannibal................................................(660) 385-8252

Kansas City District-Kansas City ………………………..(816) 607-2144 Central District-Jefferson City ...........................................(573) 522-5168

St. Louis District- Chesterfield...........................................(314) 453-1717

Southwest District-Springfield ...........................................(417) 621-6528

Southeast District-Sikeston ................................................(573) 472-5363

## MSHP Contact – Contact the insurance representative:

GHQ – Jefferson City ...........................(573) 526-6356 or (573) 526-6136

MSHP Troops: Contact your troop insurance representative.

Troop A - Lee’s Summit............................ (816) 622-0800, ext. 3119

Troop B - Macon ....................................... (660) 385-2132, ext. 3239

Troop C - St. Louis.................................... (636) 300-2800, ext. 3333

Troop D - Springfield ................................ (417) 895-6868, ext. 3452

Troop E - Poplar Bluff .............................. (573) 840-9500, ext. 3521

Troop F - Jefferson City............................ (573) 751-1000, ext. 3622

Troop G - Willow Springs ......................... (417) 469-3121, ext. 3726

Troop H - St. Joseph .................................. (816) 387-2345, ext. 3816

Troop I - Rolla………………………….. (573) 368-2345, ext. 3917

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## How to Contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486- 2048) Helpline

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 (sometimes called “CMS”). This agency contracts with Medicare Prescription Drug Plans, including us.

### Here Are Ways to Get Help and Information About Medicare From CMS:

**MEDICARE**

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free. Or you can visit the Medicare website at [www.medicare.gov.](http://www.medicare.gov/) This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

• **Medicare Eligibility Tool**: Provides Medicare eligibility status information.

• **Medicare Plan Finder**: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about MoDOT/MSHP Medical and Life Insurance Plan:

* **Tell Medicare about your complaint:** You can submit a complaint about MoDOT/MSHP Medical and Life Insurance Plan directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

## STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Missouri, the SHIP is called CLAIM.

**CLAIM** is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. **CLAIM** counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. CLAIM counselors can also help you understand your Medicare plan choices and answer questions about switching plans. You can call **CLAIM** at **1-800-390-3330 (toll free) or 1-573-817-8320 (local).** You can learn more about **CLAIM** by visiting their website [www.missouriclaim.org](http://www.missouriclaim.org) or emailing them at claim@primaris.org. If contacting **CLAIM** by email be sure to never include any personal health information (PHI) or sensitive personal information, such as a social security number.

**QUALITY IMPROVEMENT ORGANIZATION (QIO)**

## There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Missouri, the Quality Improvement Organization is called TMF.

## TMF has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. TMF is an independent organization. It is not connected with our plan.

## You should contact TMF at 1-800-725-9216 or [www.tmf.org](http://www.tmf.org) if you have a complaint about the quality of care you have received. For example, you can contact TMF medications that interact in a negative way.

##

## MEDICAID *(a joint Federal and state program that helps with medical costs for some people with limited income and resources)*

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

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

## Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

## Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

## Qualified Individual (QI): Helps pay Part B premiums.

## Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

## To find out more about Medicaid and its programs, contact MO HealthNet (Missouri’s Medicaid program) at 1-573-751-3425 or <http://dss.mo.gov/mhd/> .

##

## SOCIAL SECURITY ADMINISTRATION

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount 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, it is important that you contact Social Security to let them know.

 If you have questions about any of these benefits you can call the Social Security Administration at 1-800-772-1213 Monday through Friday 7:00am ET to 7:00 pm. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit [<https://www.ssa.gov/>.](http://www.ssa.gov/)

## RAILROAD RETIREMENT BOARD

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency. At 1-877-722-5722 Monday through Friday 9:00 am to 3:30 pm. TTY/TDD users should call 1-312-751-4701. You can also visit <https://secure.rrb.gov/>.

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

### What is a Part D Plan?

There are different types of Medicare plans. MoDOT/MSHP Medical and Life Insurance Plan is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

This supplement to the EOC explains your benefits and services, what you have to pay and the rules you must follow to get your prescription drugs covered. The EOC and other Plan documents can be found at our website: [**https://www.modot.org/medicare**](https://www.modot.org/medicare). You can also contact the Employee Benefits staff at 1-877-863-9406 and request a copy of the EOC and/or any other document to be mailed or emailed to you.

### Overview of Medicare Prescription Drug Coverage

Your prescription drug coverage has not changed. As a member, all you have to do is continue to pay your monthly premium and pay applicable deductibles, co-pays and co-insurances. If you have limited income and resources, you may get extra help from Medicare to pay your premium, deductible, co-payments and co-insurances so that you get your prescription drugs for little or no cost.

### Help Us Keep Your Membership Record Current

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

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

Let us know about the following changes:

* Changes to your name, your address, or your phone number
* Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or Medicaid)
* If you have any liability claims, such as claims from an automobile accident
* If you have been admitted to a nursing home
* If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Employee Benefits (phone numbers are printed on the back cover of this booklet).

It is also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 6, Section 1.4 of this booklet.

### Use your Plan Membership Card Instead of Your Red, White, and Blue Medicare card

While you are a member of our plan, you must use your membership card for our plan for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card. Here’s a sample membership card to show you what yours will look like:

RxBIN: 015574 RxPCN ASPROD1 RxGrp: MDT02

Issuer: (80840)

Name: John S Sample ID: 999999999

**CMS-E4744 801**

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Employee Benefits right away and we will 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.

### Using Plan Pharmacies to get Your Prescription Drugs Covered

**Network pharmacies**

Your prescriptions are covered only if they are filled at the plan’s network pharmacies.

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

How do you find a network pharmacy in your area?

To find a network pharmacy, you can use the Pharmacy Locator which can be found on our website <https://www.modot.org/medicare> or look in the Pharmacy Directory which can be mailed to you. As a reminder, our website has the most up-to-date information about our pharmacy network (Pharmacy Directory) and our list of covered drugs (Formulary/Drug List). You can also contact the Employee Benefits staff at 1-877-863-9406 and request a copy of the Pharmacy Directory and/or Formulary to be mailed or emailed to you.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan’s network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Employee Benefits (phone numbers are printed on the back cover of this booklet) or use the Pharmacy Directory found on our website at <https://www.modot.org/medicare>.

What if you need a specialized pharmacy?

Sometimes 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 long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Employee Benefits.
* 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 that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, call Employee Benefits (phone numbers are printed on the back cover of this booklet).

**Mail Order Services**

Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

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

To get information about filling your prescriptions by mail you may contact Postal Prescription Solutions at –1-800-552-6694—or visit <https://www.modot.org/medicare>.

Usually a mail-order pharmacy order will get to you in no more than 5 - 7 days. If you are unable to get a prescription timely utilizing the mail service, contact Employee Benefits for assistance.

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

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

**Refills on mail order prescriptions.** For refills, please contact your pharmacy 5 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you.

### Extra Help with Drug Plan Costs for People with Limited Income and Resources

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

* **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:
* 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
* The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
* Your State Medicaid Office (applications).
* **Help from your state’s pharmaceutical** **assistance program.** Missouri has a program called Missouri State Pharmacy Assistance Programsthat helps people pay for prescription drugs based on their financial need, age, or medical condition*.* To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet)
* **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP)helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Missouri AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-533-2437.

### Monthly Premium

As a member of our plan, you pay a monthly plan premium. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

***Please Note:*** *If you are receiving extra help with paying for your drug coverage, the premium amount that you pay will not be listed below.*

## MoDOT/MSHP 2022 MEDICAL INSURANCE PREMIUMS

|  |  |  |  |
| --- | --- | --- | --- |
| **EFFECTIVE JANUARY 1, 2022** | **Premium** | **Employer Share** | **Subscribers Cost\*** |
| **MEDICARE MEMBERS** |
| Retiree - Medicare Subscriber Only | $332.00 | $189.00 | $143.00 |
| Retiree - Medicare Subscriber/Non-MedicareSpouse | $999.00 | $400.00 | $599.00 |
| Retiree - Medicare Subscriber/Medicare Spouse | $664.00 | $299.00 | $365.00 |
| Retiree - Medicare Subscriber/Non-MedicareFamily | $1,692.00 | $744.00 | $948.00 |
| Retiree - Medicare Subscriber/Medicare Family | $1,240.00 | $608.00 | $632.00 |
| Retiree - Medicare Subscriber/Child | $999.00 | $440.00 | $559.00 |
| Retiree - Medicare Subscriber/Medicare Child | $664.00 | $305.00 | $359.00 |
| Retiree - Medicare Subscriber/2 Children | $1,183.00 | $473.00 | $710.00 |
| Survivor - Medicare Subscriber Only | $332.00 | $189.00 | $143.00 |
| Survivor - Medicare Subscriber/Non-MedicareFamily | $1,692.00 | $744.00 | $948.00 |
| Survivor - Medicare Subscriber/Medicare Family | $1,240.00 | $608.00 | $632.00 |
| Survivor - Medicare Subscriber/Child | $999.00 | $440.00 | $559.00 |
| Survivor - Medicare Subscriber/Medicare Child | $664.00 | $305.00 | $359.00 |
| Survivor - Medicare Subscriber/2 Children | $1,183.00 | $473.00 | $710.00 |
| LTD - Medicare Subscriber Only | $332.00 | $189.00 | $143.00 |
| LTD - Medicare Subscriber/Non-Medicare Spouse | $999.00 | $400.00 | $599.00 |
| LTD - Medicare Subscriber/Medicare Spouse | $664.00 | $299.00 | $365.00 |
| LTD - Medicare Subscriber/Non-Medicare Family | $1,692.00 | $744.00 | $948.00 |
| LTD - Medicare Subscriber/Medicare Family | $1,240.00 | $608.00 | $632.00 |
| LTD - Medicare Subscriber/Child | $999.00 | $440.00 | $559.00 |

\*[**Subscribers retiring effective 1/1/2015 and later will receive a state contribution of 2 percent per year of service, not to exceed 50 percent of the Premium.**](http://www6.modot.mo.gov/premiumcalc/MainMenu.aspx)

|  |  |  |  |
| --- | --- | --- | --- |
| **EFFECTIVE JANUARY 1, 2022** | **Premium** | **Employer Share** | **Subscribers Cost\*** |
| LTD - Medicare Subscriber/2 Children | $1,183.00 | $473.00 | $710.00 |
| WRD - Medicare Subscriber Only | $332.00 | $271.00 | $61.00 |
| WRD - Medicare Subscriber/Non-Medicare Spouse | $843.00 | $688.00 | $155.00 |
| WRD - Medicare Subscriber/Medicare Spouse | $664.00 | $542.00 | $122.00 |
| WRD - Medicare Subscriber/Non-Medicare Family | $1,374.00 | $1,121.00 | $253.00 |
| WRD - Medicare Subscriber/Medicare Family | $1,094.00 | $892.00 | $202.00 |
| WRD - Medicare Subscriber/Child | $536.00 | $437.00 | $99.00 |
| WRD - Medicare Subscriber/2 Children | $739.00 | $603.00 | $136.00 |
| Vested - Medicare Subscriber Only | $332.00 | $0.00 | $332.00 |
| Vested - Medicare Subscriber/Non-Medicare Family | $1,374.00 | $0.00 | $1,374.00 |
| Vested - Medicare Subscriber/Medicare Family | $1,094.00 | $0.00 | $1,094.00 |
| Vested - Medicare Subscriber/Medicare Spouse | $664.00 | $0.00 | $664.00 |
| Vested - Medicare Subscriber/Non-MedicareSpouse | $843.00 | $0.00 | $843.00 |
| Vested - Medicare Subscriber/Child | $536.00 | $0.00 | $536.00 |
| Vested - Medicare Subscriber/2 Children | $739.00 | $0.00 | $739.00 |
| Retiree-Non-Medicare Subscriber/Medicare Child | $999.00 | $460.00 | $539.00 |
| Retiree-Non-Medicare Subscriber/Medicare Spouse | $999.00 | $450.00 | $549.00 |
| Survivor - Non-Medicare Subscriber/MedicareChild | $999.00 | $460.00 | $539.00 |
| Vested - Non-Medicare Subscriber/MedicareSpouse | $999.00 | $0.00 | $999.00 |

LTD = Long Term Disability WRD = Work Related Disability

\*[**Subscribers retiring effective 1/1/2015 and later will receive a state contribution of 2 percent per year of service, not to exceed 50 percent of the Premium.**](http://www6.modot.mo.gov/premiumcalc/MainMenu.aspx)

If you have any questions about your plan premiums or the different ways to pay them, please call our MoDOT/MSHP Employee Benefits numbers listed on page 3.

Failure to pay your past-due plan premiums within the grace period will result in your disenrollment. Disenrollment ends your membership in our Plan. If you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Election Period, unless you qualify for a Special Enrollment Period.

To be a member of our Plan, you must either be entitled to Medicare Part A and/or enrolled in Medicare Part B and live in our service area. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a member of this plan.

You will have to pay a late enrollment penalty in addition to your monthly plan premium if you do not enroll in a Medicare Prescription Drug Plan during your initial enrollment period and you do not have *creditable* coverage for a continuous period of at least 63 days after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as

long as you have Medicare prescription drug coverage. The amount of the late enrollment penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. If you get extra help, your penalty amount may be lower than it is for those who don’t qualify. In addition, you may only have to pay the penalty for a maximum of 60 months.

### Prescription Drug Coverage

This section describes your prescription drug coverage as a member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

## Drugs Covered by the Plan

The plan has a “*List of Covered Drugs (Formulary).”* In this supplement to the *Evidence of Coverage*, **we call it the “Drug List” for short.** An up-to-date list of our Drug List can be found on our website at <https://www.modot.org/medicare>.

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

The drugs on the Drug List are only those covered under Medicare Part D.

We will generally cover a drug on the plan’s Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A “medically accepted indication” is a use of the drug that is *either*:

* Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
* *-- or --* Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

* In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
* In other cases, we have decided not to include a particular drug on our Drug List.

## Under the Plan, standard excluded drugs include (some exceptions apply):

* OTC products or over-the counter equivalents and state restricted drugs (unless specifically included)
* Therapeutic devices or appliances such as pulmo-aid pumps, mini-med pumps, etc. (check with the medical plan administrator)
* Immunization agents, vaccines not covered by Medicare Part D, diagnostic agents, general anesthetics and biologicals
* Implantable time-released medication (i.e. Norplant) unless otherwise noted as stated in Section 6.01(b)(i)(C)(4), (Zoladex is a Standard Covered Drug)
* Agents when used for cosmetics purposes
* Multi-Vitamins
* Experimental or investigational drugs; or drugs prescribed for experimental (non-FDA apporoved/unlabeled) indications
* Solodyn which is an extended release form of minocycline, a tetracycline
* Nutritional supplements
* Agents when used for weight loss / weight gain
* Agents when used to treat infertility
* Erectile dysfunction drugs
* Extemporaneously prepared combinations of raw bulk chemical ingredients (i.e. progesterone, testosterone, or estrogen powders) or combinations of federal legend drugs in a non-FDA approved dosage form (i.e. capsules or suppositories made from DHEA, progesterone, testosterone or estrogen powders)
* Homeopathic legend Products
* Lost, spilled, dropped, stolen etc. medications
* Drugs covered under Medicare Part A or Part B, including diabetic supplies

If you have questions about whether your prescription is covered under the plan, please contact MedImpact Employee Benefits.

### Drug Management Programs

**Utilization management:** For certain prescription drugs, there are additional requirements or limitations for coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. Examples of utilization management tools are described below:

**Prior Authorization:** For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “prior authorization.” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

**Quantity Limits:** For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is 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.

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

**Generic Substitution:** Generally, a “generic” drug works the same as a brand name drug and usually costs less. In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version. If your provider has written “No substitutions” on your prescription for a brand name drug OR has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. Your share of the cost may be greater for the brand name drug than for the generic drug.

**Drug Utilization Review:** We conduct drug utilization reviews to make sure our members are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. Drug utilization reviews are performed each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

* Possible medication errors
* Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
* Drugs that are inappropriate because of your age or gender
* Possible harmful interactions between drugs you are taking
* Drug allergies
* Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

### Medication Therapy Management (MTM) Programs

## We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

## This program is voluntary and free to qualifying members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through the MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take 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 of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You’ll also get a personal medication list that will include all the medications you’re taking and why you take them.

## It’s a good idea to have your medication review before your yearly “Wellness” visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list 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 will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Employee Benefits

## How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

## Your enrollment in MoDOT/MSHP Medical and Life Insurance Plan doesn’t affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare’s coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can’t cover it, even if you choose not to enroll in Part A or Part B.

## Some drugs may be covered under Medicare Part B in some situations and through MoDOT/MSHP Medical and Life Insurance Plan in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or MoDOT/MSHP Medical and Life Insurance Plan for the drug.

## How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. If you are qualified for extra help, specific information on the level of assistance with premiums and cost sharing will be sent to you.

Drug costs for each coverage level are described on the next page.

**Medicare**

**Assigned**

**Claims**

**Medicare**

**Non-**

**Assigned**

**Claims**

**In-Network**

**Out-of-Network**

**Individual Deductible per Calendar year**

$600

$600

$600

$600

**Coinsurance**

0%

0%

10% (up to out-of-pocket

maximum)

20% of out-of-network rate (up to

out-of-pocket maximum)

**Individual Out-of-Pocket Maximum per**

**Calendar Year**

$0

$0

$1,950

(deductible

&

copays

included)

$2,955 (deductible and copays

included) plus any costs above the

out-of-network rate

**Lifetime Maximum**

Unlimited

Unlimited

Unlimited

Unlimited

**Individual Deductible per Calendar year**

**Generic**

**Single Source Brand Medications**

**(No generic equivalent available)**

**Brand Medications**

**(Generic equivalent available)**

**Generic Medications**

**in Part D Coverage Gap\***

**Single Source Brand Medications**

**in Part D Coverage Gap\***

**(No generic equivalent available)**

**Brand Medications**

**in Part D Coverage Gap\***

**(Generic equivalent available)**

**Catastrophic Copayment Level per**

**calendar year**

**\*In 2022, the Part D Coverage Gap begins when the total cost for prescription drugs for the year reaches $4,430.00**

Once an individual reaches $7,050 of out-of-pocket expense, the cost sharing will be reduced to the

greater of 5% coinsurance or $3.95 copayment for generics and $9.85 copayment for brands.

**MEDICARE SUPPLEMENT PLAN**

Available Nationwide

**Member's Responsibility**

**Prescription Benefit - Available Through Participating Pharmacies Only**

$100

30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum

copayment.

50% coinsurance after deductible per calendar year and participant is in Part D Coverage Gap.\*

50% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum

copayment.

30% coinsurance after deductible per calendar year and participant is in Part D Coverage Gap.\*

30% coinsurance after deductible per calendar year and participant is in Part D Coverage Gap.\*

**MoDOT/MSHP Medicare Supplement Plan Benefits-at-a-Glance**

**Benefit**

**Effective January 1, 2022**

Listed below is a partial outline of coverage under the MoDOT/MSHP Summary Plan Document (SPD). This should not be relied upon to fully determine coverage. See the MoDOT/MSHP SPD

for applicable limits and exclusions to coverage for health services. If differences exist between this document and the SPD, the SPD governs.

**Medicare Non-Covered Claims For Services That**

**The Plan Covers**

30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum

copayment.

MoDOT/MSHP Medicare Supplement Plan Summary of Benefits

Effective January 1, 2022

Listed below is a partial outline of coverage under the MoDOT/MSHP Summary Plan Document (SPD). This should not be relied upon to fully determine coverage. See the MoDOT/ MSHP SPD for applicable limits and exclusions to coverage for health services. If differences exist between this document and the SPD, the SPD governs.

**Explanation of Benefits**

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

* We keep track of how much you have paid. This is called your “out-of-pocket” cost.
* We keep track of your “total drug costs.” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the Part D Explanation of Benefits (it is sometimes called the “EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

* Information for that month. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
* Totals for the year since January 1. This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

**If you are admitted to a hospital for a Medicare-covered stay**

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

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

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage.

If you cancel your coverage with our plan, you will not be eligible to reenroll at a later date.

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

Check your Pharmacy Directory to find out if your long-term care facility’s pharmacy is part of our network. If it isn’t, or if you need more information, please contact Employee Benefits (phone numbers are printed on the back cover of this booklet).

What if you’re a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership. The total supply will be for a maximum of 90 days or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug’s coverage, we will cover one 31 day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

### If You Have Other Prescription Drug Coverage

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

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

## If you have retiree coverage, Medicare pays first.

## If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

## If you’re under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.

## If you’re over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that 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.

## If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Employee Benefits. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

## If you are a member of a State Pharmacy Assistance Program (SPAP)

## If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than “Extra Help”), you still get the 50% discount on covered brand name drugs. Also, the plan pays 15% of the costs of brand drugs in the coverage gap. The 50% discount and the 15% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

## If you have a Medigap policy with prescription drug coverage

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

## Each year your Medigap insurance company should send you a notice 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.

## If you are a member of an employer or retiree group other than MoDOT/MSHP

Do you currently have other prescription drug coverage through your (or your spouse’s) employer or retiree group? If so, please contact that group’s benefits administrator. He or she can help you determine how your current prescription drug coverage will work with our plan.

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

**Special note about ‘creditable coverage**’:

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

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

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

### Coverage Determinations, Appeals and Complaints:

This section explains two types of processes for handling problems and concerns:

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

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

Which one do you use? That depends on the type of problem you are having.

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

**Asking for coverage decision**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

**Making an appeal**

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

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

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent 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.

**How to get help when you are asking for a coverage decision or making an appeal**

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

* You **can call us at Employee Benefits**
* To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program
* **Your doctor or other prescriber** **can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
* **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
	+ There may be someone who is already legally authorized to act as your representative under State law.
	+ If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Employee Benefits and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.) 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 also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

* You ask us to make an exception, including:
	+ Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs* *(Formulary)*
	+ Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
	+ Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
* You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *List of Covered Drugs* *(Formulary)* but we require you to get approval from us before we will cover it for you.)
	+ *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
* You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

**What is an exception**

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

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

**Your doctor must tell us the medical reasons**

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

**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 the 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 for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

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

Deadlines for a “fast” coverage decision

* If we are using the fast deadlines, we must give you our answer **within 24 hours**.
	+ Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
	+ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
* **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
* **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

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

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

* We must give you our answer **within 14 calendar days** after we receive your request.
	+ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
* **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
* **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

If we say no to your coverage request, you decide if you want to make an appeal.

If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

What to do

* **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
	+ For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called *How to contact us when you are making an appeal about your Part D prescription drugs.*
* **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your Part D prescription drugs*).
* **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (*How to contact our plan when you are making an appeal about your Part D prescription drugs*).
* **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
* **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
* **You can ask for a copy of the information in your appeal and add more information.**
	+ You have the right to ask us for a copy of the information regarding your appeal.
	+ If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Deadlines for a “fast” appeal

* If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
	+ If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.)
* **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
* **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

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

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

* If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
* If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

**How to make a Level 2 Appeal**

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

* 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 review organization.
* When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file**.
* You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization does a review of your appeal and gives you an answer.

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

Deadlines for “fast appeal” at Level 2

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

Deadlines for “standard appeal” at Level 2

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

What if the review organization says no to your appeal?

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

If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

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

* There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
* If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

The Level 3 Appeal is handled by an administrative law judge. Section 6 in the EOC tells more about Levels 3, 4, and 5 of the appeals process.

**Complaints/Grievances**

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

The formal name for “making a complaint” is “filing a grievance”

Contact us promptly – either by phone or in writing.

* **Usually, calling Employee Benefits is the first step.** If there is anything else you need to do, Employee Benefits will let you know. 877-863-9406 for additional information. (TTY users should call 711.) Hours are Monday through Friday 7:30 am until 4:00 pm CST.
* **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
* **Whether you call or write, you should contact Employee Benefits right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
* **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” complaint**. If you have a “fast” complaint, it means we will give you **an answer within 24 hours**.

We look into your complaint and give you our answer.

* **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
* **Most complaints are answered in 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 day’s total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
* **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

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

* **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
	+ 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.
	+ To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
* **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

You can submit a complaint about MoDOT/MSHP Medical and Life Insurance Plan directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

### Disenrollment as a Member of this Plan

**“Disenrollment”** from our Plan means ending your membership with us. Disenrollment can be voluntary (your own choice) or, in limited circumstances, involuntary (not your own choice). Our Plan cannot ask you to leave because of your health.

Disenrollment is further explained in the **Missouri Department of Transportation (MoDOT) and Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan (sponsored by the Missouri Highways and Transportation Commission) SPD.** If you have any questions regarding disenrollment, please contact Employee Benefits.

### Your Rights and Responsibilities as a Member of this Plan

**Introduction about your rights and protections**

You can read the Medicare & You 2021 Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## There are several places where you can get more information about your rights:

## You can call Employee Benefits (phone numbers are printed on the back cover of this booklet).

## You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.

## You can contact Medicare.

* + You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: https://www.medicare.gov/Pubs/pdf/11534.pdf.)

## Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

##  Your right to be treated with fairness and respect

## Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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

## If you have a disability and need help with access to care, please call us at Member. If you have a complaint, such as a problem with wheelchair access, Employee Benefits can help.

## Your right to the privacy of your medical records and personal health information

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

## Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

## The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. 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.

## In most situations, if we 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 first. Written permission can be given by you or by someone you have given legal power to make decisions for you.

## There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

## For example, we are required to release health information to government agencies that are checking on quality of care.

## Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

## You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will 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 are not routine.

## If you have questions or concerns about the privacy of your personal health information, please call Employee Benefits.

## Your right to get your prescriptions filled within a reasonable period of time

## As a member of our plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of the EOC tells what you can do. (If we have denied coverage for your prescription drugs and you don’t agree with our decision, Chapter 7, Section 4 of the EOC tells what you can do.)

## Your right to know your treatment choices and participate in decisions about your health care

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

## Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, 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.

## The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

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

## Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Employee Benefits to ask for the forms (phone numbers are printed on the back cover of this booklet).

## Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

## Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

## If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

## If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

## Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

## What if your instructions are not followed?

## If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Missouri Department of Health and Senior Services, Health Service Regulation at complaint@health.mo.gov.

## Your right to make complaints

## If you have any problems or concerns about your covered services or care, Chapter 7 of the EOC tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

## You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Employee Benefits.

## Your right to get information about the plan, its network of pharmacies, and your covered drugs

As a member of MoDOT/MSHP Medical and Life Insurance Plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Employee Benefits:

* Information about our plan. This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
* Information about our network pharmacies.
* For example, you have the right to get information from us about the pharmacies in our network.
* For a list of the pharmacies in the plan’s network, see the http://www.modot.org/newsandinfo/benefits.htm.
* For more detailed information about our pharmacies, you can call Employee Benefits or visit our website at http://www.modot.org/newsandinfo/benefits.htm.
* Information about your coverage and the rules you must follow when using your coverage.
* To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan’s List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
* If you have questions about the rules or restrictions, please call Employee Benefits.
* Information about why something is not covered and what you can do about it.
* If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
* If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of the EOC. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
* If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of the EOC.

## How to get more information about your rights

## There are several places where you can get more information about your rights:

## You can call Employee Benefits (phone numbers are printed on the back cover of this booklet).

## You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.

## You can contact Medicare.

* You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf))

## Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## What can you do if you think you have been treated unfairly or your rights are not being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Employee Benefits numbers listed on page 3 or your State Health Insurance Assistance Program.

## What are your responsibilities as a member of our Plan?

Along with the rights you have as a member of our Plan, you also have some responsibilities. Your responsibilities include the following:

Become familiar with your coverage and the rules you must follow to get care as a member.

Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.

Pay your plan premiums and any co-payments you may owe for the covered drugs you get.

Let us know if you have any questions, concerns, problems, or suggestions. If you do, please call our Employee Benefits numbers listed on page 3.

### Legal Notices

**Notice about governing law**

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

## Notice about nondiscrimination

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

**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, MoDOT/MSHP Medical and Life Insurance Plan, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

Pursuant to Section 104.270, RSMo, the plan requires the Participant/Subscriber to reimburse the plan for any medical claims paid by the plan for which there was third-party liability.