



Open Enrollment Edition

Open Enrollment is your once-a-year opportunity to enroll in or change plans and add or drop eligible dependents from coverage. The only other opportunity you have to make changes is when you experience a qualifying life event. While PEEHIP is committed to providing you with benefits that promote your health and well-being, it is your responsibility to make educated choices and select the plan(s) that are right for you and your family.

Important Open Enrollment Dates

Open Enrollment begins July 1, 2015, and will end by the following deadlines:

- ◆ **Online:** Open Enrollment ends midnight **September 10, 2015**. After this time, online Open Enrollment changes will not be accepted and the Open Enrollment link will be closed. **Online enrollment is the easiest, most efficient and preferred method of enrolling or making changes.**
- ◆ **Paper:** Open Enrollment ends **August 31, 2015**. Any paper forms postmarked after August 31, 2015, will not be accepted.
- ◆ **Flexible Spending Accounts:** Paper or online Flexible Spending Account enrollment ends **September 30, 2015**.

Effective Date of Coverage:

All Open Enrollment elections approved by PEEHIP will have an effective date of **October 1, 2015**.

Open Enrollment Web Page

Visit the PEEHIP Open Enrollment web page at www.rsa-al.gov/index.php/members/peehip/open-enrollment to find the information you need to make informed decisions about your health plan selections. You will find the deadlines, the updated PEEHIP Member Handbook with the open enrollment changes effective for October 1, 2015, and other information relating to open enrollment.

What's New

- ◆ The changes approved by the PEEHIP Board at the May 2015 meeting effective for October 1, 2015, are included in this month's *PEEHIP Advisor*.
- ◆ Open Enrollment information is published in the PEEHIP Member Handbook again this year. Active and retired members can view and/or download a copy of the handbook from the PEEHIP Open Enrollment web page referenced above. If you do not have Internet access, we can mail it to you by calling RSA Member Services at 877.517.0020.

Online Open Enrollment

The preferred method for making your Open Enrollment changes is online through **Member Online Services (MOS)** which gives you a confirmation page confirming your changes and your premium calculation. Each year, the majority of our members elect to make their changes online.

1. Go to www.rsa-al.gov and click MOS Login at the top right of the web page.
2. Enter your self-selected User ID and Password
 - ◆ **New User:** Click Register Now to create your own User ID and Password.
 - ◆ **Forgot User ID and/or Password:** Click Reset Account and provide the requested information.
3. Click "Enroll or Change PEEHIP Coverages" from the PEEHIP menu.
4. Click the Open Enrollment option and then click Continue and follow the on-screen prompts until you receive your Confirmation page.

For members who do not have Internet access and wish to make Open Enrollment changes, we can mail the form to you by calling RSA Member Services at 877.517.0020.

Helpful Information about Open Enrollment

- ◆ You do not need to do anything during Open Enrollment if you are satisfied with your current coverage. If you take no action, you and your covered dependents will remain on your current plan(s).
- ◆ **Exception:** If you want to renew your **Flexible Spending Accounts** or **Federal Poverty Level Premium Discount Program**, you must **re-enroll each year** as these two programs do not automatically renew.
- ◆ Members enrolling in new insurance plans should receive a new ID card no later than the last week in September.

Summary of Benefits and Coverage Availability of Summary Health Information

The Patient Protection and Affordable Care Act (PPACA) of 2010 created a federal requirement for group health plans to provide the **Summary of Benefits and Coverage (SBC)** form to health plan members during Open Enrollment.

Health benefits represent a significant component of every employee's compensation package. The benefits also provide important protection for employees and their family in the case of illness or injury.

PEEHIP offers health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, PEEHIP makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about health coverage options in a standard format to help you compare across coverage options available to you in both the individual market and group health insurance coverage markets.

The SBC is available on the PEEHIP web page at www.rsa-al.gov/index.php/members/peehip/benefits-policies. A paper copy is also available, free of charge, by calling Member Services toll-free at 877.517.0020.

The SBC is meant as a summary only and the coverage examples in the SBC on pages 2 and 7 are for illustration purposes only and may not be representative of the actual charges for copayments or out-of-pocket expenses for the PEEHIP plan. For more detailed benefit information, see the **PEEHIP Summary Plan Description (SPD)** at www.rsa-al.gov/index.php/members/peehip/pubs-forms.

Federal Poverty Level Premium Discount Program

PEEHIP provides premium assistance to qualifying members (active and retired) based on the Federal Poverty Level (FPL). A PEEHIP member who has a combined family income of 300% or less of the FPL may qualify for a reduced premium on his or her PEEHIP Hospital Medical or HMO premium and may reapply for the discount during Open Enrollment for an October 1, 2015, effective date, or apply anytime during the year for a prospective effective date.

The discount does not apply to the optional coverage plan premiums. The discount can reduce the member's monthly premium by 10, 20, 30, 40 or 50% depending on the member's income.

To apply for FPL premium assistance, submit the FEDERAL POVERTY LEVEL ASSISTANCE APPLICATION with a copy of your signed 2014 Federal Income Tax Return forms and copies of all supporting 1099s and W-2s. The FPL form is available on the PEEHIP web page at www.rsa-al.gov/index.php/members/peehip/pubs-forms. The FPL premium discount is effective for the plan year only and recertification and reenrollment is required annually during Open Enrollment. ●

Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirement listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from the requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Public Education Employees' Health Insurance Board has elected to exempt the PEEHIP from the following requirement:

- ◆ Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from this federal requirement will be in effect for the plan year beginning October 1, 2005. The election will be renewed every subsequent plan year.

For more information regarding this notice, please contact PEEHIP. ●



Benefit and Premium Changes Effective October 1, 2015

PEEHIP Board and Staff Working Hard to Maintain High Level of Services & Benefits

Don Yancey, PEEHIP/RSA Deputy Director
Sarah S. Swindle, PEEHIP Board Chair

Medical and pharmaceutical costs have increased at a much greater rate than expected this year due in part to new and expensive medical and drug treatments, an increase in drug prices, and increased medical utilization. The PEEHIP Board and staff work hard to save money where possible. Because of your participation, the Wellness Program has and will continue to save the plan tens of millions of dollars annually and, more importantly, help our members stay healthier.

The trend of increased costs is a national one and beyond the control of the Board or staff. As a result, PEEHIP anticipates a \$140 million dollar shortfall in funding for FY 2016 despite the Legislature's appropriation to the plan of over \$900 million. This shortfall is more than the Board can obtain from any other funding source.

The PEEHIP Board and staff care deeply about the financial challenges members face. But it was confronted with difficult choices that had to be made to ensure the survival of your health care plan. After much thought and deliberation, the PEEHIP Board voted on May 28, 2015, to implement changes to the plan. **These changes, which are described below, were required to keep PEEHIP financially solvent so that our members can count on coverage when they need it.**

Please know that the PEEHIP Board and staff have adopted changes that will minimize the financial hardship on membership. Even taking these changes into account, the PEEHIP plan remains one of the most affordable health care plans in the country. The PEEHIP Board and staff will continue to work to find ways to keep your health care as affordable as possible while maintaining a high level of service and benefits. ●

Medical Plan Changes

- ◆ **Specialist office visit copay increases from \$30 to \$35** - This does not apply to Family/General Practice, Internal Medicine, Gynecology, Obstetrics, Pediatrics, Certified Nurse Practitioner, Physician Assistant, Clinic, and Midwives.
- ◆ **Removal of 4th quarter major medical carryover deductible** - Effective January 1, 2016, major medical claims in the 4th quarter of the calendar year will no longer be carried over and counted towards the deductible of the following year.
- ◆ **Removal of the accident rider** - The accident rider previously allowed first dollar coverage for accidents up to \$500. Members were not required to pay the Emergency Room (ER) copay of \$150 in the event of an accident. Removing this rider treats accidents like any other illness and all applicable copays will apply. ●

Premium Rate Changes

These rate changes apply to active and retired members, members who are on leave of absence, COBRA, and surviving dependent accounts.

- ◆ **Increase tobacco premium from \$28 to \$50 for the subscriber AND an additional \$50 for the spouse per month if both are tobacco users.**
- ◆ **Increase family dental premium from \$45 to \$50 per month.** The single dental rate remains \$38. The other optional plan premiums remain \$38 per month.
- ◆ **Spousal Surcharge:** Add a **monthly** spousal surcharge of \$75 for spouses on active contracts and non-Medicare eligible spouses on retired contracts, and \$25 surcharge for Medicare primary spouses on retired contracts. **The spousal surcharge will be phased in over 3 years.** The spousal surcharge will not apply to spouses who are independently eligible for PEEHIP. See the three-year phase-in on page 2. ●

Spousal Surcharge Three-Year Phase-In Schedule

Spouses on active contracts and non-Medicare eligible spouses on retired contracts

Year 1: \$25	Effective 10/1/2015
Year 2: \$50	Effective 10/1/2016
Year 3: \$75	Effective 10/1/2017

Medicare primary spouses on retired contracts

Year 1: \$10	Effective 10/1/2015
Year 2: \$20	Effective 10/1/2016
Year 3: \$25	Effective 10/1/2017

Viva Health Plan Benefit Changes

- ◆ Increase drug copay to \$60 for preferred brand and \$80 for non-preferred brand.
- ◆ Change in coverage for biological drugs, biotechnical drugs, and specialty drugs to 70%.
- ◆ Change in coverage to 90% for outpatient services performed in an outpatient hospital setting. \$150 copay remains for outpatient services performed at an ambulatory surgical center.
- ◆ Increase in copay per lab test at independent labs to \$7.50 and 90% coverage per test at hospital-based labs.
- ◆ Increase in inpatient copay to \$50 for days 2-5.
- ◆ Increase in Emergency Room copay to \$200 copay per visit.
- ◆ Change diagnostic services (e.g., CT scans, X-rays, etc.) from \$150 copay per service to 90% coverage.
- ◆ Change in coverage for genetic testing, dialysis, and allergy testing and treatment to 80%.
- ◆ Combine medical and prescription out of pocket maximums (currently separate). Set the combined member out of pocket maximum to \$6,600 for an individual, and \$13,200 for the family per calendar year. ●

PEEHIP Supplemental Medical Changes

The following additions and revisions were made to the **current** exclusion language for the PEEHIP Supplemental Medical Plan.

- ◆ Members enrolled in the VIVA Health plan offered through PEEHIP cannot also be enrolled in the PEEHIP Supplemental Medical Plan.
- ◆ Members are not eligible for the PEEHIP Supplemental Medical Plan if they have a primary plan with a deductible greater than **\$1,450** for individual or **\$2,700** for family. Prior amounts were \$1,250 for individual and \$2,500 for family.
- ◆ Annual maximum amount paid for the PEEHIP Supplemental Medical Plan will be indexed to match the Hospital Medical overall maximum out of pocket (MOOP). Currently the MOOP is \$6,600 for single coverage, and \$13,200 for family coverage per calendar year. ●

Pharmacy Plan Changes

Pharmacy plan changes do not apply to PEEHIP's Medicare GenerationRx Program except where notated or the VIVA Health Plan.

- ◆ Flu Vaccine to be allowed at most participating retail pharmacies at no cost beginning August 1, 2015. Medicare-eligible members on retired contracts will continue to file their flu vaccine under Medicare Part B.
- ◆ All bulk chemical powder ingredients found in compound medications will be excluded from coverage effective July 1, 2015, under the PEEHIP commercial drug plan, and August 1, 2015, under the EGWP prescription drug program. Bulk chemical compounds are not FDA approved medications.
- ◆ The new PCSK-9 drugs for cholesterol will not be covered under PEEHIP. These high cost specialty drugs are not yet available but are expected to be on the market by late summer with an estimated cost between \$7,000 and \$12,000 annually per patient. These drugs offer additional cholesterol-lowering benefits over widely used statin medicines, but they lack the long-term effectiveness and safety information already available for the much lower-priced generics. There is not yet data to show that the new therapies cut the incidence of heart attack or death. Side effects include possible mental impairment. Until the efficacy is proven and the cost comes down significantly, these drugs will remain excluded under the PEEHIP. A nutritious diet and exercise are also healthy ways to lower cholesterol.
- ◆ Eight therapeutic classes of drugs will be closed effective October 1, 2015, by excluding high-cost brand drugs in these classes to drive utilization to the lower cost therapeutic generic alternative drugs. This results in cost savings to the plan and to members by lowering their copay to \$6. Notification letters will be sent to both the members and their prescribing physicians making them aware of these changes and allowing time to switch to the generic alternative drug in the class.

Indication	Preferred Drugs	Excluded Drugs
Benign Prostate Hypertrophy (BPH)	alfuzosin; finasteride; tamsulosin	Avodart; Flomax; Proscar; Rapaflo; Utoxatral; Jalyn
Allergic rhinitis	azelastine; olapatadine	Astelin; Astepro; Patanase
Allergic rhinitis	budesonide; triamcinolone	Beconase AQ; Nasacort AQ; Nasonex; Omnaris; Qnasl; Rhinocort Aqua; Veramyst; Nasarel; Zytonna; Dymista
Allergic rhinitis	desloratadine; levocetirizine	Clarinet; Clarinet-D; Xyzal
GERD, Ulcers	esomeprazole; lansoprazole; omeprazole; omeprazole/ sodium bicarb; pantoprazole; rabeprazole	Aciphex; Dexilant; Nexium; Prevacid; Prilosec; Protonix; Zegerid
Insomnia	eszopiclone; zaleplon; zolpidem; zolpidem CR	Ambien; Ambien CR; Edluar; Intermezzo; Lunesta; Rozerem; Intermezzo; Zolpimist; Silenor
Migraine	naratriptan; sumatriptan; rizatriptan; zolmitriptan	Alsuma; Amerge; Axert; Frova; Imitrex; Maxalt; Maxalt MLT; Relpax; Sumavel Dosepro; Treximet; Zomig; Zomig ZMT
Overactive bladder	oxybutynin; tolterodine; tolterodine LA; trospium; trospium XR	Detrol; Detrol LA; Ditropan XL; Enablex; Gelnique; Myrbetriq; Oxytrol; Sanctura; Sanctura XR; Toviaz; Vesicare

- ◆ The growth hormone therapeutic class of drugs will be closed effective October 1 2015, preferring the lower cost Omnitrope drug and excluding the following six drugs in this class: Genotropin, Humatrope, Norditropin, Nutropin, Saizen, Tev-Tropin. These are very high cost specialty drugs and preferring the lower cost drug in the class results in cost savings to the plan and to members by lowering their copay from \$60 to the \$40 preferred brand copay. Notification letters will be sent to both the members and their prescribing physicians making them aware of these changes and allowing time to switch to Omnitrope.
- ◆ Effective January 1, 2016, PEEHIP will switch to a Plus Closed Formulary for the Medicare GenerationRx prescription drug plan (EGWP), which is strictly limited to what is listed in the formulary and anything else would reject. There are generally several drugs in a therapeutic class that all treat the same condition, though some have a higher cost to the plan and higher copays for members. A closed formulary limits the number of drugs in a therapeutic class to prefer the lower cost drugs, saving money for the plan and our members. Members could get the excluded drug through the Prior Authorization process if approved.
- ◆ Various other changes to the commercial plan formulary were made, including step therapy, prior authorization, quantity limits, and exclusion of certain other drugs to drive utilization to lower cost alternative drugs. This does **not** change the normal current three-tier drug copayments of \$6 for generics, \$40 for preferred brands, and \$60 for non-preferred brands. These changes will be published in a subsequent *PEEHIP Advisor*. ●

Flex Plan Changes

Effective October 1, 2015, the Flex Debit Card will no longer be available as a reimbursement method option under the PEEHIP Health Flex Spending Account. Members will continue to have the automatic bump and the manual reimbursement method options.

The annual maximum healthcare contribution is indexed to \$2,550 beginning October 1, 2015.

Adjustments to COBRA, Leave of Absence, Surviving Spouse/Dependent and Sliding Scale Rates

As mandated by federal COBRA Law and state law (Section 16-25A-8(e)) related to Surviving Spouses paying the cost of their coverage, there will be increases to these rates. Also, members who retired on or after October 1, 2005, will experience rate adjustments because their premiums are subject to the sliding scale law (Section 16-25A-8.1) and are based on years of service and the cost of the insurance program. An age and subsidy component may also apply for members retiring on or after January 1, 2012. The PEEHIP retiree premium calculators with the new rates will be available on the RSA website prior to October 1, 2015. These rates are before any applicable tobacco or wellness premiums.

Hospital Medical or VIVA Health Plan	COBRA & Leave of Absence Rates
Single	\$444
Family	\$1,131
Family plus spouse	\$1,156
Supplemental Medical Plan	\$164

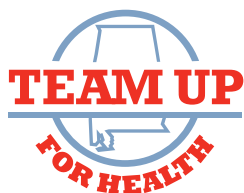
Hospital Medical or VIVA Health Plan	Surviving Spouse/Dependent Rates
Single/Non-Medicare-eligible	\$740
Family/Non-Medicare-eligible & Non-Medicare-eligible Dependents	\$987
Family/Non-Medicare-eligible & Only Dependent Medicare-eligible	\$1,033
Single/Medicare-eligible	\$425
Family/Medicare-eligible & Non-Medicare-eligible Dependent	\$679
Family/Medicare-eligible & Only Dependent Medicare-eligible	\$725

Public Education Employees' Health Insurance Plan
 201 South Union Street
 P.O. Box 302150
 Montgomery, Alabama 36130-2150



Phone: 877.517.0020, 334.517.7000
 Fax: 877.517.0021, 334.517.7001
 Email: peehipinfo@rsa-al.gov
 Web: www.rsa-al.gov

PEEHIP Wellness Program Continues Next Year



The PEEHIP *Team Up For Health* Wellness Program has moved forward tremendously over the year to become tailored to the needs of the PEEHIP membership. As of early June, the number of members complete with all required activities was over 114,000 (76% of our goal), and increasing significantly each week.

PEEHIP wants every single member to complete the required activities by the July 15, 2015, deadline, so the program has made significant improvements over the year in the number of nurses available to give wellness screenings, the number of nurses and professional health coaches to offer telephonic coaching calls, and the ease of use and clarity of the www.MyActiveHealth.com/PEEHIP website.

PEEHIP is continuing to customize the Wellness Program to best serve the PEEHIP membership for the upcoming year. The required activities will start again this fall, so be sure to watch future *PEEHIP Advisor* newsletters to see specifically what will be the minimum activities for this coming year.

If you have not already completed your activities for this first year, time is almost up! Visit www.MyActiveHealth.com/PEEHIP or call 855.294.6580 today to check what you need to do to ensure you earn a waiver of the upcoming \$50 monthly wellness premium. ●

ActiveHealth Ongoing Outreach to PEEHIP Members

Although you may have already completed your required activities to earning the \$50 monthly wellness premium waiver, ActiveHealth may continue to reach out to you.



ActiveHealth is here to help PEEHIP members pair up with a licensed nurse or professional health coach **over the phone** to work towards individual health and wellness goals all year long! You may receive a call or letter inviting you to continue to participate in the health coaching program, even after you have completed all of your required activities.

We want our members to continue to participate in the PEEHIP *Team Up for Health* Wellness Program with ActiveHealth and the telephonic coaching program as they continue to outreach to the PEEHIP population. By working together, we will achieve better health and a stronger PEEHIP plan. ●



Verify Your Wellness Program Completion with PEEHIP

If you would like extra assurance that you have completed all required activities and earned your \$50 monthly wellness premium waiver beginning this October 1, 2015, visit PEEHIP's Member Online Services (MOS) at <https://mso.rsa-al.gov> today and click the "Wellness Completion Status" link. This page will show the start and end date of the time period for which you have earned your wellness premium waiver. ●

Important Notice About Your Prescription Drug Coverage & Medicare

Please read this notice carefully and keep it with your other important documents. This notice has information about your current prescription drug coverage with PEEHIP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a standard Medicare drug plan or keep your PEEHIP drug coverage.

Effective January 1, 2013, the PEEHIP prescription drug benefit for Medicare retirees and Medicare covered dependents changed to the PEEHIP Employer Group Waiver Plan (EGWP), which is PEEHIP's Medicare Prescription Part D Drug Plan called Medicare GenerationRx. All PEEHIP covered Medicare eligible retirees and Medicare covered dependents are automatically enrolled in Medicare GenerationRx unless you are enrolled in another Part D plan or you choose to opt-out. If you opt-out of this plan, you will have no prescription coverage from PEEHIP.

If you are considering joining a standard Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. If you choose to enroll in a standard Medicare Part D drug plan, you will lose the PEEHIP prescription drug coverage.

There are two important things you need to know about your current coverage and Medicare's standard prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a standard Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All standard Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. PEEHIP has determined that the prescription drug coverage offered by the PEEHIP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing PEEHIP coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a standard Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a standard Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. If you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a standard Medicare drug plan.

What Happens To Your Current PEEHIP Coverage If You Decide to Join A Standard Medicare Drug Plan?

If you do decide to join a standard Medicare drug plan and drop your PEEHIP drug plan, your current PEEHIP drug coverage will terminate on the date that you enroll in a standard Medicare drug plan. Please be aware that you will lose the PEEHIP drug coverage and will not be able to get this coverage back until you drop the other standard Medicare Part D coverage. You cannot have PEEHIP prescription drug coverage and a standard Part D coverage plan at the same time. If you enroll in a standard Medicare drug plan, you will still be eligible for your current PEEHIP health benefits but will have no prescription drug coverage under PEEHIP.

When Will You Pay A Higher Premium (Penalty) To Join A Standard Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PEEHIP and do not join a standard Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare

base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact PEEHIP at 877.517.0020 for further information. You will receive this notice each year in the *PEEHIP Advisor* and you may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by standard Medicare drug plans.

For more information about Medicare prescription drug coverage:

- ◆ Visit www.medicare.gov.
- ◆ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- ◆ Call 800-Medicar (800.633.4227). TTY users should call 877.486.2048.

An exception may apply to certain "low-income" individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and Standard Part D (two separate steps). For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Keep this Creditable Coverage notice. If you decide to join one of the standard Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage., and therefore, whether or not you are required to pay a higher premium (a penalty). ●