The PEEHIP ADVISOR
PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN

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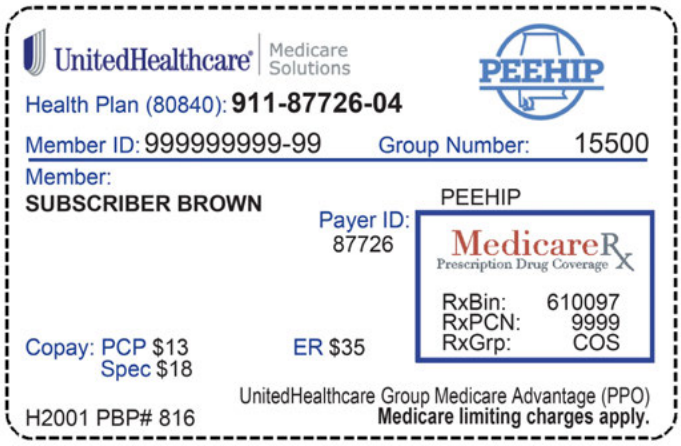
Medicare-Eligible PEEHIP Members
Things to Know About Your New UnitedHealthcare® Group Medicare Advantage (PPO) Plan

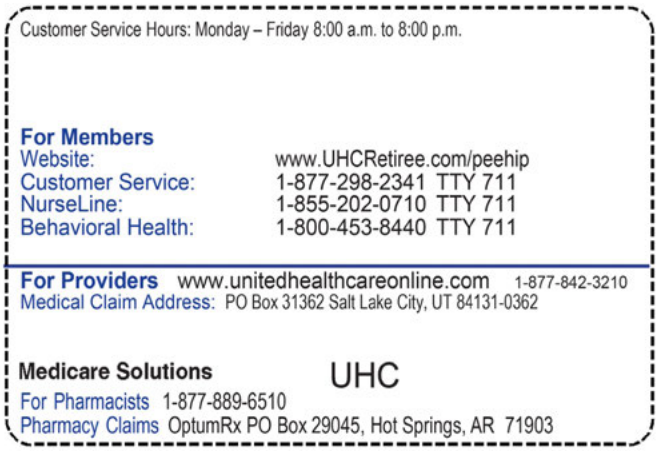
PEEHIP hospital medical and prescription drug coverage for Medicare-eligible PEEHIP retirees is now provided by the UnitedHealthcare® Group Medicare Advantage PPO plan. In previous *PEEHIP Advisors*, which can be found at www.rsa-al.gov/index.php/members/peehip/pubs-forms/peehip-newsletters, we stated that this plan not only provides a comparable level of benefits, but also includes some extra benefits that were not included in your previous coverage.

Because this is a new plan, there are some things to know about how this plan works differently than the previous PEEHIP Hospital Medical Plan. Change can be hard when it means we have to develop new habits for doing things – like remembering to use a new ID card. To make it easier, here are some things to remember and frequently asked questions about your new plan.

Things to Know About Your Plan

- The PEEHIP UnitedHealthcare Medicare Advantage plan is a **group** Medicare Advantage plan that was specifically designed for you as a Medicare-eligible member of PEEHIP. This plan is only available to you and your Medicare-eligible dependents. Your plan is not an individual Medicare Advantage plan meaning it is only available to PEEHIP members.
- Always use your PEEHIP UnitedHealthcare ID card when going to the doctor or hospital or getting a prescription filled. You no longer need to use your red, white, and blue Medicare card when you receive health care services, but please keep your Medicare card somewhere safe.





- Your plan has a **$166 annual deductible** (this is like the Medicare Part B deductible under your previous Medicare coverage). This means that you must pay the first $166 of all covered medical expenses you receive in the year before your PEEHIP UnitedHealthcare plan starts to pay for your covered medical services. After you pay the first $166 of medical costs, you will pay a copay or coinsurance depending on the type of medical service you receive.

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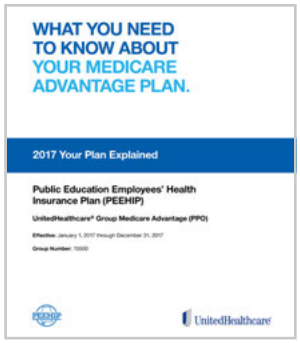
After you pay your co-pay or co-insurance, your PEEHIP UnitedHealthcare plan pays the rest of the cost for that covered medical service. Please refer to your Plan Summary of Benefits or Evidence of Coverage for more information on costs.



- If you have more questions about how the PEEHIP UnitedHealthcare Group® Medicare Advantage (PPO) plan works, UnitedHealthcare has created an expanded version of its *Your Plan Explained* that includes more detailed plan information, an expanded question and answer section, and a list of helpful resources – all in one place. You can find it online at www.rsa-al.gov/uploads/files/UHC_Your_Plan_Explained_1-1-17.PDF as well as www.uhcretiree.com/peehip/review_plan_benefits.html.
- You also can always call UnitedHealthcare customer service toll free at 877.298.2341 TTY 711, 8 a.m. to 8 p.m. local time, Monday - Friday.

Frequently Asked Questions about Your Plan's Pharmacy Benefits

1. **Am I able to receive a 90-day supply of my medication?** Yes, your pharmacy benefit allows you to obtain a 90-day supply of a medication at a retail pharmacy that is on the PEEHIP **Maintenance Drug List**. However, if you are obtaining your maintenance medication for the first time, your first prescription will be limited to a 30-day supply. After your first fill, you can receive quantities up to, but not more than, a 90-day supply as long as the prescription is written for 90 days and no more than 130 days have lapsed between medication fills. Prior Authorization may be required for certain drugs. Due to an error, you may have had a problem in obtaining a 90-day supply. This error has been fixed. If this happened to you, please contact your pharmacist to tell them you want a 90-day supply on your next fill. To determine if your medication is on the Maintenance Drug List and any other questions, you can contact UnitedHealthcare Customer Service at 877.298.2341, TTY 711 or go online to www.UHCRetiree.com/peehip.
2. **What if the drug I'm taking requires a prior authorization?** If the drug you are taking requires a prior authorization, in many cases you will be given at least a 30-day supply to give you time to talk to your doctor. This is called a "transition fill". If your doctor decides to keep you on the drug, you or your doctor can ask for coverage of the drug in 2017 by calling UnitedHealthcare Customer Service toll free at 877.298.2341 TTY 711, 8 a.m. to 8 p.m. local time, Monday - Friday. If you continue to fill your prescriptions for the drug without getting a prior authorization, the drug will not be covered and you may have to pay the full retail price.
3. **What if my drug is not on the covered drug list (formulary)?** If you find that the drug you are taking is not covered, talk to your doctor to see if other options are available for you. You may be eligible for at least a 30-day supply transition fill that allows you time to talk to your doctor. If none of the other drug options work for you, either you or your doctor can request an exception to have the drug covered for you. You can request the exception by calling UnitedHealthcare Customer Service toll free at 877.298.2341 TTY 711, 8 a.m. to 8 p.m. local time, Monday - Friday. Your doctor can call OptumRx directly at 800.711.4555, TTY 711, 7 a.m. to 2 a.m. CT, Monday through Friday; 8 a.m. to 5 p.m. CT, Saturday.
4. **What if I request a prior authorization or an exception to have my drug covered and it is denied?** If UnitedHealthcare says "no" to your request to cover your drug (also called a coverage determination), you have the right to request an appeal. Requesting an appeal means asking UnitedHealthcare to reconsider – and possibly change – the decision they made. An appeal to the plan about a Part D drug coverage decision also is called a plan "redetermination".

How to Appeal a Part D Drug Coverage Decision: If you decide to appeal the decision, here are the general steps you will need to take. Please refer to your UnitedHealthcare® Group Medicare Advantage (PPO) plan Evidence of Coverage for more details.

STEP 1: The first time you make an appeal, it is called a Level 1 Appeal. To start your Level 1 Appeal, you (or your representative or your doctor or other prescriber) must contact UnitedHealthcare. You can do this by calling UnitedHealthcare Customer Service, but you can also mail or fax your appeal. For details on how to reach them by phone, fax, or mail, or on their 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". Some things to keep in mind:

- You must make your appeal request within 60 calendar days from the date on the written notice UnitedHealthcare sent to tell you its answer to your request for a coverage decision.

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Team Up for Health
Wellness Program Reminder

PEEHIP and its partners, the Alabama Department of Public Health (ADPH) and ActiveHealth, would like to remind you of the free benefits included with your PEEHIP Hospital Medical (Group #14000) coverage. This program is designed to help PEEHIP members live happier, healthier and more satisfying lives, which also creates both out-of-pocket savings for members by avoiding health-related complications and procedures and claim savings for the plan. The more members take advantage of this Program, the more they will benefit!

1. You can receive one free wellness screening per year (restarting every August 1) from the Alabama Department of Public Health (ADPH) at your workplace or at one of the participating County Health Departments. Please visit **https://dph1.adph.state.al.us/PublicCal/** to see if there is an onsite screening scheduled in your area and sign up for your screening today!
   - ♦ If you choose to see your primary care physician instead, please remember your coverage only provides one wellness screening office visit per calendar year. Remember to take a Healthcare Provider Screening Form, located at **www.rsa-al.gov/uploads/files/PEEHIP_HCP_screening_form_and_notice.pdf**, along with you.
2. ActiveHealth has several free services of which you can take advantage. This includes a Health Questionnaire (HQ) to help you identify any potential health risks so that you can improve your health and well being. The HQ can be found at **www.MyActiveHealth.com/PEEHIP** under the "My Required Activities" link. It is also accessible by phone at 855.294.6580.
3. In addition to the HQ, ActiveHealth also offers a wide range of Health Coaching including Wellness Coaching and Disease Management. This coaching is available at **www.MyActiveHealth.com/PEEHIP**, telephonically by calling ActiveHealth at 855.294.6580, and even onsite at your workplace through an onsite ActiveHealth Certified Health Coach or Registered Dietitian.
4. The **safe and secure** **www.MyActiveHealth.com/PEEHIP** website is also available on the go via your tablet or smartphone. Besides Digital Health Coaching and the HQ, you will find several useful tools on the ActiveHealth website. There is a library full of health and wellness information, including webinars, healthy recipes, videos, audio files, and interactive tools. There is also a place to keep track of your fitness goals and appointments. If you want to connect with people with similar health concerns, you could even join one of their Social Communities.

These programs will not only help you feel better, but they will get you one step closer to earning your $50 monthly wellness premium waiver. Check your "My Required Activities" at **www.MyActiveHealth.com/PEEHIP** and complete each required activity shown by August 31, 2017, to earn your $50 monthly wellness premium waiver for the upcoming plan year. Visit **www.rsa-al.gov/index.php/members/peehip/health-wellness/** for more information.

Who is required to participate in the Wellness Program?

The following members enrolled in the PEEHIP Hospital Medical (Group # 14000) plan are required to complete all required activities in order to obtain their $50 monthly wellness premium waiver:

- ♦ Active Employees
- ♦ Non-Medicare-eligible retirees
- ♦ All covered spouses of active employees and non-Medicare-eligible spouses of retirees

Children, Medicare-eligible retirees, Medicare-eligible spouses of retirees, and any members who are not enrolled in the PEEHIP Hospital Medical (Group #14000) plan are **not** required to participate and will not be charged any wellness premium related to this Wellness Program. ●

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- If you are asking for a standard appeal, make your appeal by submitting a written request or calling UnitedHealthcare Customer Service toll free at 877.298.2341, 8 a.m. – 8 p.m. local time, Monday – Friday.
- If your health requires a quick response, you may ask for a "fast" appeal. This can be done in writing or you may call UnitedHealthcare toll free at 800.595.9532, 8 a.m. – 8 p.m. local time, 7 days a week.

STEP 2: UnitedHealthcare considers your request and gives you an answer.

- Decisions for a "fast appeal" must be made within 24 hours of when they receive your request. If you are requesting an exception, the decision will be made within 24 hours of receiving a statement supporting your request from your doctor.
- Decisions for a "standard appeal" if you have not yet received your drug must be made within 72 hours after they receive your request. If you are requesting an exception, the decision will be made within 72 hours of receiving a statement supporting your request from your doctor.
- Decisions for a "standard appeal" for a drug you have already bought must be made within 14 days after they receive your request.

STEP 3: If UnitedHealthcare says "no" to your appeal, you can decide if you want to appeal further.

Please refer to your UnitedHealthcare Evidence of Coverage as a reminder of these steps and for more information on how to make a Level 2 appeal. ●

Notice Concerning 1095-B and 1095-C Forms

As part of the Affordable Care Act, PEEHIP was required to provide Form 1095-B to each of its subscribers who were enrolled in the PEEHIP Blue Cross Blue Shield Hospital Medical Group #14000 plan during calendar year 2016. These forms were mailed in late February 2017. For the PEEHIP Group #14000 subscribers, you should have already received this form from PEEHIP. For PEEHIP members that were covered under the VIVA HMO plan during any point of 2016, VIVA carried the responsibility of providing the 1095-B form because they are a fully insured plan.

The 1095-B form reports "actual enrolled coverage" of active and non-Medicare-eligible retired members and COBRA beneficiaries and their covered spouses and children. This form is not required to file your taxes, but should be kept with your personal records. Your employer also was required to provide a different form, which was Form 1095-C. This form reports the "offer" of coverage to fulltime employees and their eligible spouses and dependents, but it is not applicable to retirees. **Neither of these forms require any action on the part of PEEHIP members**, but please retain your copy for your records.

Did You Have Unused Flex Money Last Year?
Flexible Spending Accounts Carryover Funds Are Now Available

If you were enrolled in a PEEHIP Health Flexible Spending Account (FSA) for the 2016 Plan Year (October 1, 2015 -September 30, 2016) and had unused funds remaining in your FSA account, you may still have the opportunity to use those funds. PEEHIP allows members to roll over up to $500 of unused funds remaining in their Health FSA at the end of the plan year into the next plan year to use for qualified medical expenses through the Carryover Provision.

There are a few stipulations for using these funds:

- You must have been an active Health FSA participant when the account expired on September 30, 2016.
- Funds can only be used on qualified expenses incurred between October 1, 2016, and September 30, 2017.
- Funds can only be used for qualified medical expenses for you and your eligible dependents.
- Since the funds are from an FSA, they can only be used if you remain an active employee. If you terminate employment, retire or go on a leave of absence before September 30, 2017, any funds remaining in the account will no longer be available to you.

As always, keep a copy of all receipts in the event additional information is needed to substantiate a reimbursement.

Members who are currently enrolled in the 2017 Health FSA will see that Carryover funds were automatically added to their account balance. Active members that did not re-enroll into the current plan year and have Carryover funds available will receive a notification from HealthEquity, PEEHIP's new FSA administrator, on how to access their funds. For questions concerning your Carryover funds, please contact HealthEquity Customer Service 24 hours a day at 877.288.0719. ●