

Benefit Overview

Express Scripts Medicare® (PDP) for UT CARE™

YOUR 2023 PRESCRIPTION DRUG PLAN BENEFIT

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit (which UT System refers to as the UT CARE Part D plan). You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

Plan Premium	Your group benefits administrator will tell you the amount that you pay for your plan. If you have any questions, please contact your institution's Benefits Office.																			
Member Out-of-Pocket Maximum	Your UT CARE retiree coverage includes a yearly combined medical and prescription out-of-pocket maximum (costs paid by yourself only) of \$8,700. Once you reach this amount, you will pay \$0 for your covered prescription drugs.																			
Deductible stage	You pay a \$200 yearly deductible for Medicare Part D prescription drugs in 2023. The deductible counts toward your member out-of-pocket maximum.																			
Initial Coverage stage	<p>You will pay the following until you reach the member out-of-pocket maximum of \$8,700, or until your total yearly drug costs (what you and the plan pay) reach \$4,660, whichever comes first.</p> <table border="1" data-bbox="342 1255 1481 1732"> <thead> <tr> <th data-bbox="342 1255 646 1358">Tier</th> <th data-bbox="646 1255 911 1358">Retail One-Month (31-day) Supply</th> <th data-bbox="911 1255 1175 1358">Retail Three-Month (90-day) Supply</th> <th data-bbox="1175 1255 1481 1358">Home Delivery Three-Month (90-day) Supply</th> </tr> </thead> <tbody> <tr> <td data-bbox="342 1358 646 1440">Tier 1: Generic Drugs</td> <td data-bbox="646 1358 911 1440">\$10 copayment</td> <td data-bbox="911 1358 1175 1440">\$20 copayment</td> <td data-bbox="1175 1358 1481 1440">\$20 copayment</td> </tr> <tr> <td data-bbox="342 1440 646 1543">Tier 2: Preferred Brand Drugs</td> <td data-bbox="646 1440 911 1543">\$35 copayment</td> <td data-bbox="911 1440 1175 1543">\$87.50 copayment</td> <td data-bbox="1175 1440 1481 1543">\$87.50 copayment</td> </tr> <tr> <td data-bbox="342 1543 646 1646">Tier 3: Non-Preferred Drugs</td> <td data-bbox="646 1543 911 1646">\$60 copayment</td> <td data-bbox="911 1543 1175 1646">\$150 copayment</td> <td data-bbox="1175 1543 1481 1646">\$150 copayment</td> </tr> </tbody> </table> <p data-bbox="342 1732 1481 1854">If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.</p>				Tier	Retail One-Month (31-day) Supply	Retail Three-Month (90-day) Supply	Home Delivery Three-Month (90-day) Supply	Tier 1: Generic Drugs	\$10 copayment	\$20 copayment	\$20 copayment	Tier 2: Preferred Brand Drugs	\$35 copayment	\$87.50 copayment	\$87.50 copayment	Tier 3: Non-Preferred Drugs	\$60 copayment	\$150 copayment	\$150 copayment
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	<p>You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through Express Scripts® Pharmacy. There is no charge for standard shipping. You can also get a 90-day supply of covered prescription drugs at a network retail pharmacy, including Walgreens and UT pharmacies. Not all drugs are available at a 90-day supply.</p> <p>Other pharmacies are available in our network. Express Scripts Medicare has a broad national network of pharmacies. To see if your pharmacy is in our network, visit express-scripts.com or call Express Scripts Medicare Customer Service.</p>
<p>Coverage Gap stage</p>	<p>If you have not met the member out-of-pocket maximum of \$8,700, but your total yearly drug costs reach \$4,660, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach \$7,400.</p> <p>Please note that although Medicare requires that we describe the Coverage Gap stage, your plan does not have a gap in coverage or "donut hole."</p>
<p>Catastrophic Coverage stage</p>	<p>If you have not met your member out-of-pocket maximum of \$8,700, but your yearly out-of-pocket drug costs—including manufacturer discounts—exceed \$7,400, you will pay the greater of 5% coinsurance or:</p> <ul style="list-style-type: none"> • a \$4.15 copayment for covered generic drugs (including drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage. • a \$10.35 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more details.

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- You are eligible for this plan if you are entitled to Medicare Part A and/or are enrolled in Medicare Part B, are a U.S. citizen or are lawfully present in the United States, and are eligible for benefits from UT CARE.

- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **express-scripts.com/pharmacies**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug’s tier and on the coverage stage that you’ve reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- A PDF of our printed drug list for 2023 will be available by logging into **express-scripts.com/documents** beginning on October 15, 2022.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- If you request an exception for a drug and Express Scripts Medicare approves the exception, you will pay the cost-sharing amount set by your plan for that drug.
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.
- When you use your Part D prescription drug benefits, Express Scripts Medicare sends you an *Explanation of Benefits* (Part D EOB), or summary, to help you understand and keep track of your benefits. You may also be able to receive a copy electronically by visiting our website, **express-scripts.com**, or by contacting Express Scripts Medicare Customer Service at the phone numbers on the back of this document.

For an explanation of your plan’s rules, contact Express Scripts Medicare Customer Service at the numbers on the back of this document or review the *Evidence of Coverage* (EOC) by visiting our website, **express-scripts.com/documents**. You can request a copy of the EOC by calling Express Scripts Medicare Customer Service.

Does my plan cover Medicare Part B or non–Part D drugs?

In addition to providing coverage of Medicare Part D drugs, this plan provides coverage for Medicare Part B medications, as well as for some other non–Part D medications that are not normally covered by a Medicare prescription drug plan. The amounts paid for these medications will not count toward your yearly deductible, total drug costs or total out-of-pocket expenses. Please call Customer Service for additional information about specific drug coverage and your cost-sharing amount.

Will my income affect my cost for Medicare Part D coverage?

Some people may pay an extra amount called the Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA) because of their yearly income. If you have to pay an extra amount, Social Security – *not your Medicare plan* – will send a letter telling you what the extra amount will be and how to pay it. If you have any questions about this extra amount, contact Social Security at 1.800.772.1213 between 8 a.m. and 7 p.m., Monday through Friday to speak with a representative. Automated messages are available 24 hours a day. TTY users should call 1.800.325.0778.

Read the *Medicare & You 2023 handbook*.

The *Medicare & You* handbook has a summary of Original Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. You can get a copy 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.

Express Scripts Medicare Customer Service

1.800.860.7849

24 hours a day, 7 days a week

We have free language interpreter services available for non-English speakers.

TTY: **1.800.716.3231**

You can also visit us on the Web at **express-scripts.com**.

This information is not a complete description of benefits. Call Express Scripts Medicare at the phone numbers above for more information.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. If your plan has a deductible, there is no deductible for covered vaccines. Call Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than \$35 for a one-month supply for each insulin product covered by our plan, no matter its cost-sharing tier. If your plan covers insulin at a lower cost-sharing amount, you will pay the lower amount. If your plan has a deductible, there is no deductible for covered insulins.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

This document may be available in braille. Please call Customer Service at the phone numbers listed above for assistance.

For questions about premiums, enrollment and eligibility, please contact your institution's Benefits Office at the numbers listed in your pre-notification letter or the *Quick Reference Guide* in your Welcome Kit.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

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