

2019 ENROLLMENT GUIDE



Get familiar with your Prescription Drug plan.

AARP® MedicareRx Preferred (PDP)
AARP® MedicareRx Saver Plus (PDP)

S5805-001

S5921-379

Region: 03

Service area: New York

Plan Year: January 1, 2019 through December 31, 2019

Benefits Beyond Expectations

More choice and more guidance

Everyone's health needs are different. That's why we offer a broad range of Medicare products. And we're here to help guide you through finding the right plan.

Customer service that puts you first

Our compassionate Customer Service Advocates are an important part of your personal health care team — ready to answer your questions, schedule your appointments and help you manage your health.

A health care company you can rely on

1 in 5 Medicare beneficiaries trust UnitedHealthcare with their coverage.¹ And we've been serving people just like you for more than 40 years — so you know we'll be here when you need us.

The only Medicare plans that carry the AARP name

UnitedHealthcare has an exclusive relationship with AARP to offer Medicare plans with the AARP name. We're aligned in believing Medicare beneficiaries should have access to affordable, quality health care.

Member-only Health & Wellness Experience

We all want to live a healthier, happier life and Renew by UnitedHealthcare can be your guide. With Renew, you'll have access to inspiring lifestyle tips, learning activities, videos, recipes, interactive health tools, rewards and more — all designed to help you live your best life at no additional cost to you.²



¹2018 Internal Company Data

²Renew by UnitedHealthcare is not available in all plans. Renew Rewards is not available in all plans that include Renew by UnitedHealthcare.

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Have questions? We can help

Toll-free **1-888-867-5564**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

Learn more online at
www.AARPMedicarePlans.com


Start With Medicare Basics

Make sure this plan is a good fit by reviewing the basics

Original Medicare is provided by the federal government and covers some of the costs of hospital stays (Part A) and doctor visits (Part B), but doesn't cover everything. It does not include prescription drug coverage (Part D). Although you are not required to enroll in Part D, there is a penalty of 1% of the average monthly premium for each month you delay enrollment. This must be paid monthly as long as you are enrolled in Part D. Depending on your needs, you may want to add on more coverage.


Original Medicare
Provided by the federal government

PART
A



Helps pay for hospital stays and inpatient care

PART
B



Helps pay for doctor visits and outpatient care

Your options for more coverage:


OPTION 1

OR

OPTION 2

Add one or both of the following to Original Medicare:


Medicare Supplement Insurance Plan
Offered by private companies



Helps pay some of the out-of-pocket costs that come with Original Medicare

Medicare Part D Plan
Offered by private companies

PART
D




Helps pay for prescription drugs

Choose a Medicare Advantage plan:


Medicare Advantage Plan
Offered by private companies

PART
C




Combines Part A (hospital insurance) and Part B (medical insurance) in one plan

PART
D



Usually includes prescription drug coverage



May offer additional benefits not provided by Original Medicare

Medicare Made Clear® brought to you by UnitedHealthcare®

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This is a Medicare Part D Prescription Drug plan (PDP)

Here's how your Medicare Part D plan works



What does it cover?

Original Medicare (Parts A and B) does not include prescription drug coverage. Medicare Part D plans cover certain prescription drugs. When comparing Medicare Part D coverage, check each plan's formulary (drug list) to make sure your drugs are included.

- The federal government sets guidelines for the types of drugs Medicare Part D plans must cover
- Each Medicare Part D plan decides which specific drugs it will cover and what members will pay
- Medicare Part D plans are available to those eligible for Medicare
- If you choose to enroll in a Part D plan, you can only do so through a private insurance company like UnitedHealthcare or other companies contracted with Medicare



When to enroll in a Medicare Part D plan.

Your Initial Enrollment Period (IEP) is 7 months long. It includes your birthday month, plus the 3 months before and the 3 months after your birthday month. Your IEP begins and ends one month earlier if your birthday is on the first of the month.

If you have creditable drug coverage through your employer or other insurance, you don't need to enroll in a Part D plan right away. Creditable drug coverage is coverage at least as good as you could get through Medicare Part D. You have a two-month Special Election Period to enroll in a Medicare Part D plan after losing other coverage. You could be charged a penalty if you go without creditable drug coverage over 63 days.

There's a Medicare Part D Late Enrollment Penalty



Although you are not required to enroll in Part D, there is a penalty of 1% of the average monthly premium for each month you delay enrollment. This must be paid monthly as long as you are enrolled in Part D.

Are you eligible for this plan?

You are eligible for a Medicare Part D plan if:



You are enrolled in Original Medicare Parts A or B (or both)

AND



Live in the plan's service area

Considerations for selecting the Part D plan that's right for you

Does the plan cover my prescription drugs?

- Enter your drugs into our online Drug Cost Estimator tool, [EstimateDrugCostsAARP.com](https://www.estimateDrugCostsAARP.com) to determine the total annual drug cost for each plan.

Which plan will be most cost effective?

- When comparing plans be sure to consider all costs, including monthly premium, copays, deductibles and the tier your drugs fall into.

Are you willing to fill at a pharmacy in the plan's Preferred Pharmacy Network?

- Using a preferred network pharmacy helps ensure that you get the lowest drug cost.

Helpful resources

Medicare Made Clear™

An educational program developed by UnitedHealthcare to help you better understand Medicare. Find out more at [MedicareMadeClear.com](https://www.MedicareMadeClear.com).

You may qualify for Extra Help

Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. To see if you qualify for Extra Help, call:

- The Social Security Administration at **1-800-772-1213**, TTY **1-800-325-0778**
- Your state Medicaid office

Formulary and Pharmacy Network

- To determine if your drugs are included in plan formularies, go to [AARPMedicarePlans.com](https://www.AARPMedicarePlans.com) and enter your drug information.
- After entering your drugs, click on the Pick a Pharmacy tab to find a Preferred Retail Pharmacy near you.
- You can also call **1-888-867-5564**, TTY **711**, 8 a.m. – 8 p.m., 7 days a week to speak with a customer service representative.

Plan Information

Benefit Highlights

This is a short description of 2019 plan benefits. For complete information, please refer to your **Summary of Benefits** or **Evidence of Coverage**.

Plan Costs

Plan Feature	AARP® MedicareRx Saver Plus (PDP)		AARP® MedicareRx Preferred (PDP)	
Monthly premium	\$59.90		\$77.70	
Annual prescription deductible	\$415		\$0	
Initial coverage stage	Preferred retail cost sharing (in-network 30-day supply)	Standard retail cost sharing (in-network 30-day supply)	Preferred retail cost sharing (in-network 30-day supply)	Standard retail cost sharing (in-network 30-day supply)
Tier 1: Preferred Generic Drugs	\$1 copay	\$6 copay	\$5 copay	\$10 copay
Tier 2: Generic Drugs	\$8 copay	\$13 copay	\$10 copay	\$20 copay
Tier 3: Preferred Brand Drugs	\$25 copay	\$30 copay	\$40 copay	\$47 copay
Tier 4: Non-Preferred Drugs	33% coinsurance	33% coinsurance	40% coinsurance	45% coinsurance
Tier 5: Specialty Tier Drugs	25% coinsurance	25% coinsurance	33% coinsurance	33% coinsurance
Coverage gap stage	After your total drug costs reach \$3,820, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap			
Catastrophic coverage stage	After your total out-of-pocket costs reach \$5,100, you will pay the greater of \$3.40 copay for generic (including brand drugs treated as generic), \$8.50 copay for all other drugs, or 5% coinsurance			
Drug List (Formulary)	Includes many generic drugs and some commonly used brand name drugs covered by Medicare Part D.		Includes most generic and commonly used brand name drugs covered by Medicare Part D.	

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is not a complete description of benefits. Contact the plan for more information. AARP® MedicareRx SaverPlus (PDP)'s pharmacy network includes limited lower-cost pharmacies in rural MT, NE, ND, SD and WY. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call us or consult the online pharmacy directory using the contact information that appears on the booklet cover.

Your Drug Plan Coverage and Costs

Make sure your drugs are covered

Find out if your prescription drugs are covered by checking the Drug List (Formulary) in this Enrollment Guide or the online Formulary at **EstimateDrugCostsAARP.com**.

Know how much your drugs will cost

The amount you pay for your drug depends on 4 factors: what tier the drug is covered in, where you are within the drug payment stages, where you purchase the drug, and whether or not you have Extra Help.

Understanding drug tiers

Many plans group covered drugs together by cost. These groupings are called tiers. Generally, the lower the tier, the less you'll have to pay.

Drug List (Formulary) Tiers				
Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Preferred Generic	Generic	Preferred Brand	Non-preferred Drug	Specialty Tier

Note: Not all generic drugs are low cost. There are generic drugs in each tier. Check the drug list for the tier of your specific generic drug.

Your Part D prescription drug costs

With Medicare Part D prescription drug coverage, the amount you pay for prescriptions may change over the year. Here's why:

- Part D plans may have 4 coverage stages: annual deductible, initial coverage, coverage gap (also known as the donut hole) and catastrophic coverage.
- The amount of money you pay changes depending on the stage you are in.
- Many people never make it further than the initial coverage stage. If you take a lot of medications, especially high-cost medications, you may move into the next stages.
- The pharmaceutical industry may increase the price of drugs at any time in a plan year and pricing for drugs may vary across pharmacies in the network.
- The coverage cycle starts over again on January 1 each plan year.

Once you're a member



You can easily track how close you are getting to the coverage gap stage by signing in to your account online.

Explore ways to save time and money

✓ Spend less at select pharmacies¹

You could save even more on your prescription drugs by using one of the pharmacies in our Preferred Retail Pharmacy network. The locations listed below are just some of the participating pharmacies.² Visit **FindMyPharmacyAARP.com** to find a location near you.



✓ Try OptumRx® home delivery

Get a 90-day supply of your medications delivered through OptumRx, our preferred home delivery pharmacy.

OptumRx will send the prescriptions you take regularly right to your door with no cost for standard shipping. Register online at **OptumRx.com** to order new prescriptions, request refills and more.

✓ Consider generic drugs

Many commonly used prescription drugs have a generic form. Ask your doctor if your drugs are available as generics and if they would be appropriate for you. Then search for the generic versions at **EstimateDrugCostsAARP.com** to determine your potential savings.

✓ Use lower-tier drugs

Prescription drugs are grouped into 5 tiers and in general, drugs in lower tiers have lower costs. If your drug is in a higher, more expensive tier, ask your doctor if there is a cheaper alternative that could work for you.

✓ Get Extra Help

If you have a limited income, you may be able to get Extra Help with your Medicare prescription drug plan premiums, deductibles and copays. To find out if you qualify, call the Social Security Administration at **1-800-772-1213**, TTY **1-800-325-0778**, 7 a.m. – 7 p.m., Monday – Friday.

¹Other pharmacies are available in our network.

²Only Rite Aid stores featuring a Walgreens pharmacy are part of the Preferred Retail Pharmacy Network. All other Rite Aid stores are in the standard retail pharmacy network.

2019 SUMMARY OF BENEFITS



Overview of your plan

AARP® MedicareRx Preferred (PDP)

S5805-001

Look inside to learn more about the drug coverages the plan provides.
Call Customer Service or go online for more information about the plan.



Toll-free 1-888-867-5564, TTY 711
8 a.m. - 8 p.m. local time, 7 days a week



www.AARPMedicarePlans.com

AARP® | MedicareRx Plans
insured through **UnitedHealthcare**

Our service area includes **New York**.

Summary of Benefits

January 1st, 2019 - December 31st, 2019

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.AARPMedicarePlans.com or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

About this plan.

AARP® MedicareRx Preferred (PDP) is a Medicare Prescription Drug Plan plan with a Medicare contract.

To join AARP® MedicareRx Preferred (PDP), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, live in our service area as listed on the cover and be a United States citizen or lawfully present in the United States.

Use network pharmacies.

AARP® MedicareRx Preferred (PDP) has a network of pharmacies. If you use out-of-network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at a network pharmacy.

You can go to www.AARPMedicarePlans.com to search for a network pharmacy using the online directory. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

AARP® MedicareRx Preferred (PDP)

Premiums and Benefits	Cost-Share
Monthly Plan Premium	\$77.70
Annual Prescription Drug Deductible	This plan does not have a deductible.

Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a Standard retail pharmacy.

Stage 1: Annual Prescription Deductible	Since you have no deductible, this payment stage doesn't apply.					
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	Retail				Mail Order	
	Preferred		Standard		Preferred	Standard
	30-day supply	90-day supply	30-day supply	90-day supply	90-day supply	90-day supply
Tier 1: Preferred Generic Drugs	\$5 copay	\$15 copay	\$10 copay	\$30 copay	\$0 copay	\$30 copay
Tier 2: Generic Drugs	\$10 copay	\$30 copay	\$20 copay	\$60 copay	\$0 copay	\$60 copay
Tier 3: Preferred Brand Drugs	\$40 copay	\$120 copay	\$47 copay	\$141 copay	\$105 copay	\$141 copay
Tier 4: Non-Preferred Drugs	40% coinsurance	40% coinsurance	45% coinsurance	45% coinsurance	40% coinsurance	45% coinsurance
Tier 5: Specialty Tier Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Stage 3: Coverage Gap Stage	After your total drug costs reach \$3,820, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.					
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,100, you pay the greater of: <ul style="list-style-type: none"> □ 5% coinsurance, or □ \$3.40 copay for generic (including brand drugs treated as generic) and a \$8.50 copay for all other drugs. 					

Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies. A Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. You do not need to be an AARP member to enroll in a Medicare Advantage or Prescription Drug Plan. AARP and its affiliates are not insurers. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at <https://www.medicare.gov> or get a copy 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.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY : 711)。

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

Premium and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

Every year, Medicare evaluates plans based on a 5-star rating system.

The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

AARP MedicareRx Preferred (PDP) and AARP MedicareRx Saver Plus (PDP)'s pharmacy network includes limited lower-cost pharmacies in rural MT, NE, ND, SD and WY. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-800-753-8004, TTY 711 or consult the online pharmacy directory at www.AARPMedicarePlans.com.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-877-266-4832, TTY 711. OptumRx is an affiliate of UnitedHealthcare Insurance Company.

Members may use any pharmacy in the network but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

2019 SUMMARY OF BENEFITS



Overview of your plan

AARP® MedicareRx Saver Plus (PDP)

S5921-379

Look inside to learn more about the drug coverages the plan provides.
Call Customer Service or go online for more information about the plan.



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About this plan.

AARP® MedicareRx Saver Plus (PDP) is a Medicare Prescription Drug Plan plan with a Medicare contract.

To join AARP® MedicareRx Saver Plus (PDP), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, live in our service area as listed on the cover and be a United States citizen or lawfully present in the United States.

Use network pharmacies.

AARP® MedicareRx Saver Plus (PDP) has a network of pharmacies. If you use out-of-network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at a network pharmacy.

You can go to www.AARPMedicarePlans.com to search for a network pharmacy using the online directory. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

AARP® MedicareRx Saver Plus (PDP)

Premiums and Benefits	Cost-Share
Monthly Plan Premium	\$59.90
Annual Prescription Drug Deductible	\$415 per year for Part D prescription drugs.

Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a Standard retail pharmacy.

Stage 1: Annual Prescription Deductible	\$415 per year.					
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	Retail				Mail Order	
	Preferred		Standard		Preferred	Standard
	30-day supply	90-day supply	30-day supply	90-day supply	90-day supply	90-day supply
Tier 1: Preferred Generic Drugs	\$1 copay	\$3 copay	\$6 copay	\$18 copay	\$3 copay	\$18 copay
Tier 2: Generic Drugs	\$8 copay	\$24 copay	\$13 copay	\$39 copay	\$24 copay	\$39 copay
Tier 3: Preferred Brand Drugs	\$25 copay	\$75 copay	\$30 copay	\$90 copay	\$75 copay	\$90 copay
Tier 4: Non-Preferred Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Tier 5: Specialty Tier Drugs	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Stage 3: Coverage Gap Stage	After your total drug costs reach \$3,820, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.					
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,100, you pay the greater of: <ul style="list-style-type: none"> □ 5% coinsurance, or □ \$3.40 copay for generic (including brand drugs treated as generic) and a \$8.50 copay for all other drugs. 					

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You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

Every year, Medicare evaluates plans based on a 5-star rating system.

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Members may use any pharmacy in the network but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Copays apply after deductible.

UnitedHealthcare - S5805

2018 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2018, UnitedHealthcare received the following Overall Star Rating from Medicare.

★★★★
3.5 stars

We received the following Summary Star Rating for UnitedHealthcare's health/drug plan services:

Health Plan Services:

Not offered

Drug Plan Services:

★★★★
3.5 stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time, at 888-867-5564 (toll-free) or 711 (TTY).

Current members please call 888-867-5575 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

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UnitedHealthcare - S5921

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3.5 stars

We received the following Summary Star Rating for UnitedHealthcare's health/drug plan services:

Health Plan Services: Not offered

Drug Plan Services: ★★★★★
3.5 stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time, at 888-867-5564 (toll-free) or 711 (TTY).

Current members please call 866-460-8854 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY : 711).

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the member toll-free phone number listed in the front of this booklet.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed in the front of this booklet.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付費會員電話號碼。

XIN LUU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال على رقم الهاتف المجاني للعضو الموجود في مقدمة هذا الكتيب.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان اعضا که بر روی جلد این کتابچه قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया इस पुस्तिका के सामने के पृष्ठ पर सूचीबद्ध सदस्य टोल-फ्री फ़ोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខសមាជិកឥតចេញថ្លៃ បានកត់នៅខាងមុខនៃកូនសៀវភៅនេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániłti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqódi díí naaltsoos bidáahgi t'áá jiik'eh naaltsoos báha'dít'éhígíí béesh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.

NOTES

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Drug List

Drug List

This is a partial alphabetical list of prescription drugs covered by the AARP® MedicareRx Preferred (PDP) and AARP® MedicareRx Saver Plus (PDP) Prescription Drug Plans as of August 1, 2018. This list can change throughout the year. Call us or go online for the most complete, up-to-date information. Our phone number and website are listed on the back cover of this book.

- ☐ **Brand name** drugs are in **bold** type. Generic drugs are in plain type
- ☐ Your plan may have an annual prescription deductible
- ☐ Covered drugs are placed in tiers. Each tier has a different cost
 - Tier 1: Preferred generic
 - Tier 2: Generic
 - Tier 3: Preferred brand
 - Tier 4: Non-preferred drug
 - Tier 5: Specialty tier
- ☐ See the Summary of Benefits in this book to find out what you'll pay for these drugs
- ☐ Some drugs have coverage requirements, such as Prior Authorization or Step Therapy

PA Prior authorization	The plan needs more information from your doctor to make sure the drug is being used correctly for a medical condition covered by Medicare. If you don't get prior approval, it may not be covered.
QL Quantity limits	The plan only covers a certain amount of this drug for 1 copay. Limits help make sure the drug is used safely. If your doctor prescribes more than the limit, you or your doctor can ask the plan to cover the additional quantity.
ST Step therapy	You may need to try lower-cost drugs that treat the same condition before the plan will cover your drug. If you have tried other drugs or your doctor thinks they are not right for you, you or your doctor can ask the plan for coverage.
B/D Medicare Part B or Part D	Depending on how this drug is used, it may be covered by Medicare Part B or Part D. Your doctor may need to give the plan more information about how this drug will be used to make sure it's covered correctly.
LA Limited access	The FDA only lets certain facilities or doctors give out this drug. It may require extra handling, doctor coordination or patient education.

Pr = AARP® MedicareRx Preferred Sp = AARP® MedicareRx Saver Plus NC = Not covered
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MME Morphine milligram equivalent	Additional quantity limits may apply across all drugs in the opioid class used for the treatment of pain. This additional limit is called a cumulative morphine milligram equivalent (MME), and is designed to monitor safe dosing levels of opioids for individuals who may be taking more than 1 opioid drug for pain management. If your doctor prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor can ask the plan to cover the additional quantity.
7D 7-Day limit	An opioid drug used for the treatment of acute pain may be limited to a 7 day supply for members with no recent history of opioid use. This limit is intended to minimize long-term opioid use. For members who are new to the plan, and have a recent history of using opioids, the limit may be overridden by having the pharmacy contact the plan.
DL Dispensing limit	Dispensing limits apply to this drug. This drug is limited to a 1 month supply per prescription.

Drug Name	Pr	Sp	Requirements
A			
Abacavir/Lamivudine (Tablet)	4	4	QL
Acamprosate Calcium DR (Tablet Delayed-Release)	4	4	
Acetaminophen/Codeine (120mg-12mg/5ml Oral Solution, 300mg-15mg Tablet, 300mg-30mg Tablet, 300mg-60mg Tablet)	2	2	7D,DL,QL,MME
Acetazolamide (Tablet Immediate-Release)	3	3	
Acetazolamide ER (Capsule Extended-Release 12 Hour)	4	4	
Acyclovir (200mg Capsule, 400mg Tablet, 800mg Tablet)	2	2	
Acyclovir (200mg/5ml Suspension)	4	4	
Acyclovir (5% Ointment)	4	NC	QL
Adacel (Injection)	3	3	
Adcirca (Tablet)	5	NC	PA,QL
Advair Diskus, Advair HFA (Aerosol)	3	NC	QL
Albenza (Tablet)	5	5	QL
Alcohol Prep Pads	3	3	
Alendronate Sodium (70mg/75ml Oral Solution)	4	4	
Alendronate Sodium (Tablet)	1	1	QL

Bold type = Brand name drug

Plan type = Generic drug

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Drug Name	Pr	Sp	Requirements
Alfuzosin HCl ER (Tablet Extended-Release 24 Hour)	2	2	
Allopurinol (Tablet)	1	1	
Alosetron HCl (Tablet)	5	5	PA
Alprazolam (Tablet Immediate-Release)	2	2	QL
Amantadine HCl (100mg Capsule)	3	2	
Amantadine HCl (100mg Tablet)	3	NC	
Amantadine HCl (50mg/5ml Syrup)	2	2	
Amiloride HCl (Tablet)	2	2	
Amiodarone HCl (200mg Tablet)	2	2	
Amitiza (Capsule)	3	NC	QL
Amitriptyline HCl (Tablet)	3	3	
Amlodipine Besylate (Tablet)	1	1	
Ammonium Lactate (12% Cream, 12% Lotion)	3	3	
Amoxicillin (Capsule, Oral Suspension, Tablet, Tablet Chewable)	2	2	
Amphetamine/Dextroamphetamine (10mg Capsule Extended-Release 24 Hour, 15mg Capsule Extended-Release 24 Hour, 20mg Capsule Extended-Release 24 Hour, 25mg Capsule Extended-Release 24 Hour, 30mg Capsule Extended-Release 24 Hour, 5mg Capsule Extended-Release 24 Hour)	4	4	QL
Amphetamine/Dextroamphetamine (10mg Tablet Immediate-Release, 12.5mg Tablet Immediate-Release, 15mg Tablet Immediate-Release, 20mg Tablet Immediate-Release, 30mg Tablet Immediate-Release, 5mg Tablet Immediate-Release, 7.5mg Tablet Immediate-Release)	3	3	QL
Anagrelide HCl (Capsule)	3	3	
Anastrozole (Tablet)	2	2	
Androderm (Patch 24 Hour)	3	3	QL
Anoro Ellipta (Aerosol Powder)	3	3	QL
Apriso (Capsule Extended-Release 24 Hour)	3	3	QL
Aranesp Albumin Free (100mcg/0.5ml Injection, 100mcg/ml Injection, 150mcg/0.3ml Injection, 200mcg/0.4ml Injection, 200mcg/ml Injection, 300mcg/0.6ml Injection, 300mcg/ml Injection, 500mcg/ml Injection, 60mcg/0.3ml Injection, 60mcg/ml Injection)	5	5	PA

Pr = AARP® MedicareRx Preferred

Sp = AARP® MedicareRx Saver Plus

NC = Not covered

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Drug Name	Pr	Sp	Requirements
Aranesp Albumin Free (10mcg/0.4ml Injection, 25mcg/0.42ml Injection, 25mcg/ml Injection, 40mcg/0.4ml Injection, 40mcg/ml Injection)	4	4	PA
Aripiprazole (Tablet, 1mg/ml Oral Solution)	4	4	QL
Arnuity Ellipta (Aerosol Powder)	3	NC	QL
Atazanavir Sulfate (Capsule)	5	5	QL
Atenolol (Tablet)	1	1	
Atomoxetine (Capsule)	4	4	QL
Atorvastatin Calcium (Tablet)	1	1	QL
Atovaquone/Proguanil HCl (Tablet) (Generic Malarone)	3	3	
Atripla (Tablet)	5	5	QL
Atrovent HFA (Aerosol Solution)	4	4	
Aubagio (Tablet)	5	NC	QL,LA
Auryxia (Tablet)	4	4	
Avonex (Injection)	5	NC	
Azasite (Ophthalmic Solution)	4	NC	
Azathioprine (Tablet)	2	2	B/D,PA
Azelastine HCl (0.05% Ophthalmic Solution)	3	2	
Azelastine HCl (0.1% Nasal Solution, 0.15% Nasal Solution)	3	3	
Azithromycin (500mg Injection)	4	4	
Azithromycin (Oral Suspension, Tablet)	2	2	
Azopt (Suspension)	3	NC	
B			
Baclofen (Tablet)	2	2	
Balsalazide Disodium (Capsule)	4	4	
Belsomra (Tablet)	3	3	QL
Benazepril HCl (Tablet)	1	1	QL
Benazepril HCl/Hydrochlorothiazide (Tablet)	1	1	QL
Benzotropine Mesylate (Tablet)	2	2	
Bepreve (Ophthalmic Solution)	4	NC	
Berinert (Injection)	5	5	PA,LA
Betaseron (Injection)	5	NC	

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This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Drug Name	Pr	Sp	Requirements
Bethanechol Chloride (Tablet)	2	2	
Betimol (Ophthalmic Solution)	4	4	
Bevespi Aerosphere (Aerosol)	3	3	QL
Bicalutamide (Tablet)	2	2	
Binosto (Tablet Effervescent)	4	4	QL
Bisoprolol Fumarate (Tablet)	2	2	
Bisoprolol Fumarate/Hydrochlorothiazide (Tablet)	2	NC	QL
Breo Ellipta (Aerosol Powder)	3	3	QL
Brilinta (Tablet)	3	4	QL
Brimonidine Tartrate (0.2% Ophthalmic Solution)	2	2	
Briviact (Tablet, 10mg/ml Oral Solution)	5	5	QL
Budesonide (0.25mg/2ml Suspension, 0.5mg/2ml Suspension)	4	4	B/D,PA
Budesonide (1mg/2ml Suspension)	4	NC	B/D,PA
Budesonide (3mg Capsule Delayed-Release)	4	4	
Bumetanide (0.25mg/ml Injection)	4	4	
Bumetanide (0.5mg Tablet, 1mg Tablet, 2mg Tablet)	2	2	
Buprenorphine HCl (Tablet Sublingual)	2	2	QL
Bupropion HCl SR (150mg Tablet Extended-Release 12 Hour Smoking-Deterrent)	2	2	
Bupropion HCl, Bupropion HCl SR, Bupropion HCl XL (Tablet)	2	2	
Buspirone HCl (Tablet)	2	2	
Butrans (Patch Weekly)	3	NC	7D,DL,QL
Bydureon Bcise (Auto injector)	3	3	QL
Bydureon Injection (Pen, Vial)	3	3	QL
Byetta (Injection)	4	NC	QL
Bystolic (Tablet)	3	NC	QL
C			
Cabergoline (Tablet)	3	2	
Calcitriol (0.25mcg Capsule, 0.5mcg Capsule, 1mcg/ml Oral Solution)	2	2	B/D,PA
Calcitriol (3mcg/gm Ointment)	4	4	
Calcium Acetate (667mg Capsule, 667mg Tablet)	3	2	

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Sp = AARP® MedicareRx Saver Plus

NC = Not covered

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Drug Name	Pr	Sp	Requirements
Captopril (Tablet)	2	NC	QL
Carafate (1gm/10ml Suspension)	4	4	
Carbaglu (Tablet)	5	5	LA
Carbamazepine (100mg Tablet Chewable, 100mg/5ml Suspension, 200mg Tablet Immediate-Release)	3	2	
Carbidopa/Levodopa, Carbidopa/Levodopa ER, Carbidopa/Levodopa ODT (Tablet)	2	2	
Carbidopa/Levodopa/Entacapone (Tablet)	4	4	
Carvedilol (Tablet)	1	1	
Cayston (Inhalation Solution)	5	5	PA,LA
Cefuroxime Axetil (Tablet)	2	2	
Celecoxib (Capsule)	3	NC	QL
Cephalexin (Oral Suspension, Capsule)	2	2	
Chantix (Tablet)	3	3	
Chlorhexidine Gluconate Oral Rinse (Solution)	2	2	
Chlorthalidone (Tablet)	2	2	
Cholestyramine Light (Powder)	3	3	
Cilostazol (Tablet)	2	2	
Cinryze (Injection)	5	NC	PA,LA
Ciprodex (Otic Suspension)	3	NC	
Ciprofloxacin HCl (250mg Tablet Immediate-Release, 500mg Tablet Immediate-Release, 750mg Tablet Immediate-Release)	2	2	
Citalopram HBr (10mg Tablet, 20mg Tablet, 40mg Tablet)	1	1	
Citalopram HBr (10mg/5ml Oral Solution)	3	2	
Clarithromycin (Oral Suspension)	4	4	
Clarithromycin (Tablet)	3	3	
Climara Pro (Patch Weekly)	4	4	
Clonazepam (Tablet Immediate-Release)	2	2	QL
Clonazepam ODT (Tablet Dispersible)	4	4	QL
Clonidine HCl (0.1mg/24hr Patch Weekly, 0.2mg/24hr Patch Weekly, 0.3mg/24hr Patch Weekly)	4	4	
Clonidine HCl (Tablet Immediate-Release)	2	2	
Clopidogrel (75mg Tablet)	2	2	QL

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Plan type = Generic drug

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Drug Name	Pr	Sp	Requirements
Clozapine (100mg Tablet, 25mg Tablet, 50mg Tablet, 200mg Tablet)	3	3	
Clozapine ODT (Tablet Dispersible)	4	4	QL
Colchicine (0.6mg Capsule) (Generic Mitigare)	3	3	QL
Colchicine (0.6mg Tablet) (Generic Colcris)	3	3	QL
Combigan (Ophthalmic Solution)	3	NC	
Combivent Respimat (Aerosol Solution)	3	3	
Cosentyx (Injection), Cosentyx Sensoready Pen (Injection)	5	5	PA,LA
Cosopt PF (Ophthalmic Solution)	4	4	
Creon (Capsule Delayed-Release)	3	3	
Crixivan (Capsule)	3	3	QL
Cromolyn Sodium (100mg/5ml Concentrate)	4	4	
Cromolyn Sodium (20mg/2ml Nebulized Solution)	3	3	B/D,PA
Cromolyn Sodium (4% Ophthalmic Solution)	2	2	
Cyclophosphamide (Capsule)	4	4	B/D,PA
D			
Daliresp (Tablet)	4	4	PA,QL
Dapsone (Tablet)	3	3	
Desmopressin Acetate (0.01% Nasal Rhinal Tube Solution)	4	4	
Desmopressin Acetate (0.01% Nasal Spray Solution)	4	4	
Desmopressin Acetate (0.1mg Tablet, 0.2mg Tablet)	3	2	
Dexilant (Capsule Delayed-Release)	4	NC	QL
Dextrose 5%/NaCl 0.2% (Injection)	4	4	
Dextrose 5%/NaCl 0.225% (Injection)	4	4	
Dextrose 5%/NaCl 0.33% (Injection)	4	4	
Dextrose 5%/NaCl 0.45% (Injection)	4	4	
Dextrose 5%/NaCl 0.9% (Injection)	4	4	B/D,PA
Diazepam (1mg/ml Oral Solution)	2	2	
Diazepam Intensol (5mg/ml Concentrate)	2	2	QL
Diclofenac, Diclofenac DR, Diclofenac ER (Tablet)	2	2	
Dicyclomine HCl (10mg Capsule, 10mg/5ml Oral Solution, 20mg Tablet)	2	2	

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Sp = AARP® MedicareRx Saver Plus

NC = Not covered

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Drug Name	Pr	Sp	Requirements
Digoxin (0.05mg/ml Oral Solution)	4	4	
Digoxin (125mcg Tablet, 250mcg Tablet)	2	2	
Dihydroergotamine Mesylate (Nasal Solution)	5	5	
Diltiazem HCl (Tablet Immediate-Release)	2	2	
Diltiazem HCl ER (120mg Capsule Extended-Release 24 Hour, 180mg Capsule Extended-Release 24 Hour, 240mg Capsule Extended-Release 24 Hour, 300mg Capsule Extended-Release 24 Hour) (Generic Cardizem CD)	3	2	
Diltiazem HCl ER (360mg Capsule Extended-Release 24 Hour, 420mg Capsule Extended-Release 24 Hour) (Generic Tiazac)	3	NC	
Diltiazem HCl ER (Capsule Extended-Release)	3	NC	
Diphenoxylate/Atropine (2.5mg-0.025mg Tablet, 2.5mg-0.025mg/5ml Liquid)	3	3	
Disulfiram (Tablet)	4	2	
Divalproex Capsule, Divalproex DR Tablet, Divalproex ER Tablet	2	2	
Donepezil HCl (10mg Tablet, 5mg Tablet)	2	2	QL
Donepezil HCl (23mg Tablet)	4	NC	QL
Donepezil HCl ODT (Tablet Dispersible)	2	2	QL
Dorzolamide HCl/Timolol Maleate (Ophthalmic Solution)	2	2	
Doxazosin Mesylate (Tablet)	2	2	
Doxycycline Hyclate (100mg Capsule, 50mg Capsule, 100mg Tablet Immediate-Release, 20mg Tablet Immediate-Release)	3	3	
Dronabinol (Capsule)	4	4	PA
Duavee (Tablet)	4	4	
Duloxetine HCl (20mg Capsule Delayed-Release, 30mg Capsule Delayed-Release, 60mg Capsule Delayed-Release)	2	2	QL
Durezol (Emulsion)	3	3	
Dutasteride (Capsule)	3	NC	QL
Dymista (Suspension)	4	NC	
E			
Edarbi (Tablet)	4	NC	QL
Edarbyclor (Tablet)	4	NC	QL
Elidel (Cream)	4	4	ST

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Plan type = Generic drug

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Drug Name	Pr	Sp	Requirements
Eliquis (Tablet)	3	3	QL
Elmiron (Capsule)	4	4	
Embeda (Capsule Extended-Release)	3	3	7D,DL,QL,MME
Enalapril Maleate (Tablet)	2	2	QL
Enalapril Maleate/Hydrochlorothiazide (Tablet)	2	2	QL
Enbrel (Injection)	5	NC	PA
Entacapone (Tablet)	4	4	
Entecavir (Tablet)	4	4	
Epclusa (Tablet)	5	5	PA,QL
Eplerenone (Tablet)	3	NC	
Escitalopram Oxalate (10mg Tablet, 20mg Tablet, 5mg Tablet, 5mg/5ml Oral Solution)	2	2	
Estradiol (0.025mg/24hr Patch Weekly, 0.05mg/24hr Patch Weekly, 0.06mg/24hr Patch Weekly, 0.075mg/24hr Patch Weekly, 0.1mg/24hr Patch Weekly, 37.5mcg/24hr Patch Weekly)	2	2	QL
Estradiol (0.1mg/gm Cream)	4	NC	
Estradiol (0.5mg Tablet, 1mg Tablet, 2mg Tablet) (Generic Estrace)	2	2	
Eszopiclone (Tablet)	3	NC	QL
Ethosuximide (250mg Capsule)	3	2	
Ethosuximide (250mg/5ml Oral Solution)	4	2	
Exjade (Tablet Soluble)	5	NC	PA
Extavia (Injection)	NC	5	
Ezetimibe (Tablet)	2	3	QL
F			
Famotidine (20mg Tablet, 40mg Tablet)	2	NC	
Fareston (Tablet)	5	5	
Farxiga (Tablet)	NC	3	QL
Fenofibrate (145mg Tablet, 48mg Tablet)	3	NC	
Fenofibrate (160mg Tablet, 54mg Tablet)	2	2	
Fentanyl (100mcg/hr Patch 72 Hour, 12mcg/hr Patch 72 Hour, 25mcg/hr Patch 72 Hour, 50mcg/hr Patch 72 Hour, 75mcg/hr Patch 72 Hour)	3	3	7D,DL,QL,MME
Finasteride (5mg Tablet) (Generic Proscar)	2	2	

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Drug Name	Pr	Sp	Requirements
Firazyr (Injection)	5	5	PA,QL,LA
Flovent Diskus (Aerosol Powder)	3	NC	QL
Flovent HFA (Aerosol)	3	NC	QL
Fluconazole (Tablet, Suspension)	2	2	
Fluocinolone Acetonide (0.01% Cream, 0.025% Cream, 0.025% Ointment)	3	3	
Fluocinolone Acetonide (0.01% External Solution)	4	4	
Fluocinolone Acetonide (0.01% Otic Oil)	4	4	
Fluphenazine HCl (2.5mg/5ml Elixir, 2.5mg/ml Injection)	4	4	
Fluphenazine HCl (5mg/ml Concentrate)	3	3	
Fluphenazine HCl (Tablet)	2	2	
Fluticasone Propionate (0.005% Ointment, 0.05% Cream)	3	3	
Fluticasone Propionate (50mcg/act Suspension)	2	2	
Forteo (Injection)	5	NC	PA,QL
Furosemide (10mg/ml Injection)	4	4	B/D,PA
Furosemide (10mg/ml Oral Solution, 8mg/ml Oral Solution, 20mg Tablet, 40mg Tablet, 80mg Tablet)	1	1	
Fuzeon (Injection)	5	5	QL
Fycompa (0.5mg/ml Suspension, Tablet)	4	4	
G			
Gabapentin (250mg/5ml Oral Solution)	3	2	
Gabapentin (Capsule, Tablet)	2	2	
Gammagard Liquid (Injection)	4	NC	PA
Gemfibrozil (Tablet)	2	2	
Genotropin (12mg Injection, 5mg Injection)	5	5	PA
Genotropin Miniquick (0.2mg Injection)	4	4	PA
Genotropin Miniquick (0.4mg Injection, 0.6mg Injection, 0.8mg Injection, 1.2mg Injection, 1.4mg Injection, 1.6mg Injection, 1.8mg Injection, 1mg Injection, 2mg Injection)	5	5	PA
Gentamicin Sulfate (0.1% Cream, 0.1% Ointment, 0.3% Ophthalmic Solution)	2	2	
Gilenya (Capsule)	5	5	QL
Glatiramer Acetate (Solution Prefilled Syringe)	5	5	

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Drug Name	Pr	Sp	Requirements
Glimepiride (Tablet)	1	1	QL
Glipizide, Glipizide ER (Tablet)	1	1	QL
GlucaGen HypoKit (Injection)	4	4	
Glucagon Emergency Kit (Injection)	3	3	
Guanidine HCl (Tablet)	3	3	
H			
Haloperidol (Tablet, 2mg/ml Concentrate)	2	2	
Harvoni (Tablet)	5	5	PA,QL
Humalog (Injection)	3	3	
Humalog Mix (Injection)	3	3	
Humira (Injection)	5	5	PA
Humulin 70/30 Vial (Injection)	3	3	
Humulin N Vial (Injection)	3	3	
Humulin R Vial (Injection)	3	3	
Hydralazine HCl (Tablet)	2	2	
Hydrochlorothiazide (12.5mg Capsule, 12.5mg Tablet, 25mg Tablet, 50mg Tablet)	1	1	
Hydrocodone/Acetaminophen (10mg-325mg Tablet, 2.5mg-325mg Tablet, 5mg-325mg Tablet, 7.5mg-325mg Tablet)	3	3	7D,DL,QL,MME
Hydromorphone HCl (10mg/ml Injection, 50mg/5ml Injection)	4	4	7D,DL
Hydromorphone HCl (1mg/ml Liquid)	4	4	7D,DL,QL,MME
Hydromorphone HCl (2mg Tablet Immediate-Release, 4mg Tablet Immediate-Release, 8mg Tablet Immediate-Release)	2	2	7D,DL,QL,MME
Hydromorphone HCl (2mg/ml Injection)	4	4	7D,DL
Hydroxychloroquine Sulfate (Tablet)	2	2	
Hydroxyurea (Capsule)	2	2	
Hydroxyzine HCl (10mg Tablet, 25mg Tablet, 50mg Tablet, 10mg/5ml Syrup)	3	3	
Hysingla ER (Tablet Extended-Release 24 Hour Abuse-Deterrent)	3	3	7D,DL,QL,MME

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Drug Name	Pr	Sp	Requirements
I			
Ibandronate Sodium (Tablet)	3	3	QL
Ibuprofen (Tablets, Suspension)	2	2	
Ilevro (Suspension)	3	NC	
Imatinib Mesylate (Tablet)	5	5	PA,QL
Imiquimod (Cream)	4	4	
Incruse Ellipta (Aerosol Powder)	3	NC	QL
Insulin Syringes, Needles	3	3	
Intelence (100mg Tablet, 200mg Tablet)	5	5	QL
Intron A (Injection)	5	5	PA,LA
Invanz (Injection)	4	4	
Invokamet, Invokamet XR (Tablet)	3	NC	QL
Invokana (Tablet)	3	NC	QL
Ipratropium Bromide (0.02% Inhalation Solution)	2	2	B/D,PA
Ipratropium Bromide (0.03% Nasal Solution, 0.06% Nasal Solution)	2	2	
Ipratropium Bromide/Albuterol Sulfate (Inhalation Solution)	2	2	B/D,PA
Irbesartan (Tablet)	2	2	QL
Irbesartan/Hydrochlorothiazide (Tablet)	2	NC	QL
Isentress (400mg Tablet)	5	5	QL
Isoniazid (100mg Tablet, 300mg Tablet)	2	2	
Isoniazid (50mg/5ml Syrup)	4	4	
Isosorbide Dinitrate (Tablet Immediate-Release, Tablet Extended-Release)	2	2	
Isosorbide Mononitrate (Tablet Immediate-Release, Tablet Extended-Release 24 Hour)	2	2	
Ivermectin (Tablet)	3	3	
J			
Jadenu (Tablet)	5	4	PA
Janumet, Janumet XR (Tablet)	3	NC	QL
Januvia (Tablet)	3	NC	QL

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Drug Name	Pr	Sp	Requirements
Jardiance (Tablet)	3	3	QL
Jentaduetto, Jentaduetto XR (Tablet)	4	3	QL
Jublia (External Solution)	4	4	
K			
Kalydeco (150mg Tablet, 50mg Packet, 75mg Packet)	5	5	PA,QL,LA
Ketoconazole (2% Cream, 2% Shampoo, 200mg Tablet)	2	2	
Ketoconazole (2% Foam)	4	NC	
Ketorolac Tromethamine (10mg Tablet)	3	NC	
Ketorolac Tromethamine (Ophthalmic Solution)	3	3	
Klor-Con 10, Klor-Con 8 (Tablet)	3	3	
Klor-Con M20 (Tablet Extended-Release)	2	2	
Kombiglyze XR (Tablet Extended-Release 24 Hour)	3	3	QL
Korlym (Tablet)	5	5	PA,QL,LA
L			
Lactulose (Oral Solution)	2	2	
Lamivudine (100mg Tablet)	3	3	
Lamivudine (10mg/ml Oral Solution, 150mg Tablet, 300mg Tablet)	3	3	QL
Lamotrigine (Tablet Chewable)	3	3	
Lamotrigine (Tablet Immediate-Release)	2	2	
Lantus Injection (SoloStar, Vial)	3	3	
Lastacraft (Ophthalmic Solution)	3	3	
Latanoprost (Ophthalmic Solution)	2	1	
Latuda (Tablet)	5	5	QL
Leflunomide (Tablet)	3	3	
Letrozole (Tablet)	2	2	
Leucovorin Calcium (10mg Tablet, 15mg Tablet, 5mg Tablet)	3	3	
Leucovorin Calcium (25mg Tablet)	4	4	
Leukeran (Tablet)	4	4	
Levemir Injection (FlexTouch, Vial)	3	NC	
Levetiracetam (Tablet Immediate-Release, 100mg/ml Oral Solution)	2	3	
Levocarnitine (1gm/10ml Oral Solution)	3	3	

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Drug Name	Pr	Sp	Requirements
Levocarnitine (330mg Tablet)	3	3	
Levocetirizine Dihydrochloride (5mg Tablet)	3	3	QL
Levofloxacin (Injection, Oral Solution)	4	4	
Levofloxacin (Ophthalmic Solution, Tablet)	3	3	
Levothyroxine Sodium (Tablet)	1	1	
Lialda (Tablet Delayed-Release)	3	NC	QL
Lidocaine (5% Ointment)	4	4	QL
Lidocaine (5% Patch)	4	4	PA,QL
Lidocaine HCl (4% External Solution, 2% Viscous Solution)	2	2	
Lidocaine/Prilocaine (Cream)	3	3	
Lindane (Shampoo)	4	4	
Linzess (Capsule)	3	3	QL
Liothyronine Sodium (Tablet)	2	2	
Lisinopril (Tablet)	1	1	QL
Lisinopril/Hydrochlorothiazide (Tablet)	1	1	QL
Lithium Carbonate (Capsule, Tablet), Lithium Carbonate ER (Tablet)	2	2	
Loperamide HCl (Capsule)	2	2	
Lorazepam (Tablet, 2mg/ml Intensol Concentrate)	2	2	QL
Losartan Potassium (Tablet)	1	1	QL
Losartan Potassium/Hydrochlorothiazide (Tablet)	1	1	QL
Lotemax (0.5% Gel, 0.5% Ointment, 0.5% Suspension)	4	NC	
Lovastatin (Tablet)	2	2	QL
Lumigan (Ophthalmic Solution)	3	NC	
Lupron Depot (Injection)	5	5	PA
Lyrica (Capsule, 20mg/ml Oral Solution)	3	3	QL
Lysodren (Tablet)	5	5	
M			
Mavyret (Tablet)	5	5	PA,QL
Meclizine HCl (Tablet)	2	2	
Medroxyprogesterone Acetate (10mg Tablet, 2.5mg Tablet, 5mg Tablet)	2	2	

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Drug Name	Pr	Sp	Requirements
Medroxyprogesterone Acetate (150mg/ml Injection Prefilled Syringe)	4	4	
Meloxicam (Tablet)	1	1	
Memantine HCl (Tablet)	3	3	PA,QL
Mercaptopurine (Tablet)	3	3	
Meropenem (Injection)	4	4	
Metformin HCl (Tablet Immediate-Release)	1	1	QL
Metformin HCl ER (500mg Tablet Extended-Release 24 Hour, 750mg Tablet Extended-Release 24 Hour) (Generic Glucophage XR)	1	1	QL
Methadone HCl (10mg Tablet, 5mg Tablet, 10mg/5ml Oral Solution, 5mg/5ml Oral Solution)	3	3	7D,DL,QL,MME
Methazolamide (Tablet)	4	4	
Methimazole (Tablet)	2	2	
Methotrexate (Tablet)	2	2	
Methscopolamine Bromide (Tablet)	4	4	
Methyldopa (Tablet)	2	3	
Methylphenidate HCl (Tablet Immediate-Release) (Generic Ritalin)	3	3	QL
Metoclopramide HCl (10mg Tablet, 5mg Tablet, 5mg/5ml Oral Solution)	2	2	
Metoprolol Succinate ER (Tablet Extended-Release 24 Hour)	2	1	
Metoprolol Tartrate (100mg Tablet Immediate-Release, 25mg Tablet Immediate-Release, 50mg Tablet Immediate-Release)	1	1	
Metronidazole (0.75% Cream)	3	3	
Metronidazole (0.75% Gel)	4	3	
Metronidazole (0.75% Lotion)	4	NC	
Metronidazole (1% Gel)	4	NC	
Metronidazole (Tablet Immediate-Release)	2	2	
Migergot (Suppository)	4	4	
Minocycline HCl (Capsule)	2	2	
Minocycline HCl (Tablet Immediate-Release)	4	NC	
Minoxidil (Tablet)	2	2	
Mirtazapine, Mirtazapine ODT (Tablet)	2	2	

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Drug Name	Pr	Sp	Requirements
Misoprostol (Tablet)	3	3	
Modafinil (Tablet)	4	4	PA,QL
Mometasone Furoate (Nasal Suspension)	4	NC	
Montelukast Sodium (10mg Tablet, 4mg Packet, 4mg Tablet Chewable, 5mg Tablet Chewable)	2	2	QL
Morphine Sulfate ER (100mg Tablet Extended-Release, 15mg Tablet Extended-Release, 30mg Tablet Extended-Release, 60mg Tablet Extended-Release) (Generic MS Contin)	3	3	7D,DL,QL,MME
Morphine Sulfate ER (200mg Tablet Extended-Release) (Generic MS Contin)	4	4	7D,DL,QL,MME
Multaq (Tablet)	3	NC	QL
Myrbetriq (Tablet Extended-Release 24 Hour)	3	3	
N			
Nadolol (Tablet)	4	NC	
Naftin (1% Gel, 2% Gel)	4	NC	
Naloxone (Injection)	4	4	
Naltrexone HCl (Tablet)	3	3	
Namzaric (Therapy Pack, Capsule Extended-Release 24 Hour)	3	3	PA,QL
Naproxen (125mg/5ml Suspension)	4	4	
Naproxen (250mg Tablet Immediate-Release, 375mg Tablet Immediate-Release, 500mg Tablet Immediate-Release)	2	2	
Narcan (Nasal Spray)	3	3	
Neomycin/Polymyxin/Hydrocortisone (1% Otic Solution, 1% Otic Suspension)	3	3	
Niacin ER (Tablet Extended-Release)	4	NC	
Niacor (Tablet)	2	2	
Nicotrol (Inhaler)	4	4	
Nitrofurantoin Macrocrystals (100mg Capsule, 50mg Capsule) (Generic Macrochantin)	3	3	
Nitrofurantoin Monohydrate (100mg Capsule) (Generic Macrobid)	3	3	
Nitrostat (Tablet Sublingual)	3	3	
Nizatidine (150mg Capsule, 300mg Capsule)	NC	2	
Norethindrone Acetate (5mg Tablet)	2	2	

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Drug Name	Pr	Sp	Requirements
Nortriptyline HCl (Capsule, 10mg/5ml Oral Solution)	2	2	
Norvir (100mg Capsule, 80mg/ml Oral Solution)	4	4	QL
Norvir (100mg Tablet)	4	NC	
Nucynta ER (Tablet Extended-Release 12 Hour)	3	NC	7D,DL,QL,MME
Nuedexta (Capsule)	4	4	PA
Nutropin AQ (Injection)	5	NC	PA
Nystatin (Cream, Ointment)	2	1	
Nystatin (Powder, Suspension, Tablet)	2	2	
O			
Olanzapine (10mg Injection)	4	4	
Olanzapine (Tablet)	2	2	QL
Olmesartan Medoxomil (Tablet)	2	NC	QL
Olmesartan Medoxomil/Amlodipine/Hydrochlorothiazide (Tablet)	2	NC	QL
Olmesartan Medoxomil/Hydrochlorothiazide (Tablet)	2	NC	QL
Omega-3-Acid Ethyl Esters (Capsule) (Generic Lovaza)	4	NC	QL
Omeprazole (10mg Capsule Delayed-Release, 40mg Capsule Delayed-Release)	2	2	QL
Omeprazole (20mg Capsule Delayed-Release)	2	2	
Ondansetron HCl (24mg Tablet, 4mg Tablet, 8mg Tablet)	2	2	B/D,PA
Ondansetron HCl (4mg/5ml Oral Solution)	4	4	B/D,PA
Ondansetron ODT (Tablet Dispersible)	2	2	B/D,PA
Onglyza (Tablet)	3	3	QL
Opsumit (Tablet)	5	5	PA,LA
Orenitram (0.125mg Tablet Extended-Release)	4	4	PA,LA
Orenitram (0.25mg Tablet Extended-Release, 1mg Tablet Extended-Release, 2.5mg Tablet Extended-Release, 5mg Tablet Extended-Release)	5	5	PA,LA
Oseltamivir Phosphate (Capsule, 6mg/ml Suspension)	3	3	QL
Osphena (Tablet)	4	4	PA,QL
Oxcarbazepine (300mg/5ml Suspension)	4	4	
Oxcarbazepine (Tablet)	3	3	
Oxybutynin Chloride ER (Tablet Extended-Release 24 Hour)	3	2	QL
Oxycodone HCl (100mg/5ml Concentrate)	4	4	7D,DL,QL,MME

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Drug Name	Pr	Sp	Requirements
Oxycodone HCl (Tablet Immediate-Release, 5mg/5ml Oral Solution)	3	3	7D,DL,QL,MME
Oxycodone/Acetaminophen (Tablet)	3	3	7D,DL,QL,MME
OxyContin (Tablet Extended-Release 12 Hour Abuse-Deterrent)	3	NC	7D,DL,QL,MME
P			
Pantoprazole Sodium (20mg Tablet Delayed-Release, 40mg Tablet Delayed-Release)	2	2	QL
Pazeo (Ophthalmic Solution)	3	NC	
Pegasys (Injection)	5	5	PA
Penicillin V Potassium (Oral Solution, Tablet)	2	2	
Perforomist (Nebulized Solution)	4	4	B/D,PA,QL
Permethrin (Cream)	3	3	
Phenytoin Sodium Extended (Capsule)	2	2	
Phoslyra (Oral Solution)	3	3	
Picato (Gel)	3	3	
Pilocarpine HCl (5mg Tablet, 7.5mg Tablet)	4	4	
Pilocarpine HCl (Ophthalmic Solution)	3	3	
Pioglitazone HCl (Tablet)	1	1	QL
Polyethylene Glycol 3350 Powder (Generic MiraLAX)	2	2	
Pomalyst (Capsule)	5	5	PA,QL
Potassium Chloride ER (10meq Capsule Extended-Release, 8meq Capsule Extended-Release)	3	NC	
Potassium Chloride ER (10meq Tablet Extended-Release, 20meq Tablet Extended-Release, 8meq Tablet Extended-Release)	2	2	
Potassium Citrate ER (Tablet Extended-Release)	3	4	
Pradaxa (Capsule)	4	4	QL
Pramipexole Dihydrochloride (Tablet Immediate-Release)	3	2	
Pravastatin Sodium (Tablet)	1	1	QL
Prazosin HCl (Capsule)	2	2	
Prednisolone Acetate (Ophthalmic Suspension)	3	3	
Prednisone (Tablet Therapy Pack, Tablet, 5mg/5ml Oral Solution)	2	2	

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Drug Name	Pr	Sp	Requirements
Premarin (0.3mg Tablet, 0.45mg Tablet, 0.625mg Tablet, 0.9mg Tablet, 1.25mg Tablet)	4	4	QL
Premarin (Vaginal Cream)	3	3	
Premphase (Tablet)	4	4	QL
Prempro (Tablet)	4	4	QL
Prezista (100mg/ml Suspension, 600mg Tablet, 800mg Tablet)	5	5	QL
Prezista (150mg Tablet, 75mg Tablet)	4	4	QL
ProAir HFA, ProAir RespiClick (Aerosol)	3	NC	
Procrit (10000unit/ml Injection, 2000unit/ml Injection, 3000unit/ml Injection, 4000unit/ml Injection)	4	4	PA
Procrit (20000unit/ml Injection, 40000unit/ml Injection)	5	5	PA
Proctosol HC (Cream)	2	2	
Progesterone (Capsule)	2	NC	
Prolensa (Ophthalmic Solution)	4	4	
Prolia (Injection)	4	4	QL
Promethazine HCl (12.5mg Suppository, 25mg Suppository)	4	4	
Promethazine HCl (50mg Suppository)	4	NC	
Promethazine HCl (Tablet)	3	3	
Promethazine HCl Plain (Syrup)	3	3	
Propranolol HCl (Oral Solution, Tablet Immediate-Release, Capsule Extended-Release 24 Hour)	2	2	
Propylthiouracil (Tablet)	2	2	
Pulmicort Flexhaler (Aerosol Powder)	NC	3	QL
Pyridostigmine Bromide (Tablet Immediate-Release)	3	3	
Q			
Quetiapine Fumarate (Tablet Immediate-Release)	2	2	QL
Quinapril HCl (Tablet)	2	2	QL
Quinapril/Hydrochlorothiazide (Tablet)	2	2	QL
R			
Raloxifene HCl (Tablet)	3	2	QL
Ramipril (Capsule)	2	2	QL
Ranexa (Tablet Extended-Release 12 Hour)	3	3	QL

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Drug Name	Pr	Sp	Requirements
Ranitidine HCl (150mg Tablet, 300mg Tablet)	2	2	
Rapaflo (Capsule)	3	NC	QL
Rasagiline Mesylate (Tablet)	4	4	
Rebif (Injection)	5	NC	
Restasis (Emulsion)	3	3	QL
Revlimid (Capsule)	5	5	PA,QL,LA
Reyataz (50mg Packet)	5	5	QL
Rifabutin (Capsule)	4	4	
Rifampin (150mg Capsule, 300mg Capsule)	3	2	
Rifampin (600mg Injection)	4	4	
Riluzole (Tablet)	4	4	
Rimantadine HCl (Tablet)	4	2	
Risperidone (1mg/ml Oral Solution)	4	4	
Risperidone (Tablet)	2	2	
Rivastigmine Tartrate (Capsule)	3	2	QL
Rizatriptan, Rizatriptan ODT (Tablet)	3	2	QL
Ropinirole HCl (Tablet Immediate-Release)	2	2	
Rosuvastatin Calcium (Tablet)	2	2	QL
Rozerem (Tablet)	4	NC	QL
S			
Sancuso (Patch)	5	NC	
Santyl (Ointment)	4	4	
Saphris (Tablet Sublingual)	4	4	QL
Savella (Tablet)	3	3	
Scopolamine (Patch 72 Hour)	4	4	
Selegiline HCl (5mg Capsule, 5mg Tablet)	3	3	
Selzentry (150mg Tablet, 300mg Tablet, 75mg Tablet)	5	5	QL
Sensipar (Tablet)	5	5	B/D,PA,QL
Serevent Diskus (Aerosol Powder)	3	3	QL
Sertraline HCl (100mg Tablet, 25mg Tablet, 50mg Tablet)	1	1	
Sertraline HCl (20mg/ml Concentrate)	4	4	

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Drug Name	Pr	Sp	Requirements
Sevelamer Carbonate (0.8gm Packet, 2.4gm Packet, 800mg Tablet)	4	4	
Shingrix (Injection)	4	4	PA
Sildenafil (20mg Tablet) (Generic Revatio)	3	3	PA,QL
Silver Sulfadiazine (Cream)	3	3	
Simbrinza (Suspension)	3	3	
Simvastatin (Tablet)	1	1	QL
Sodium Polystyrene Sulfonate (Powder)	3	3	
Sotalol HCl, Sotalol HCl AF (Tablet)	2	2	
Spiriva HandiHaler Capsule, Spiriva Respimat Solution	3	3	QL
Spironolactone (Tablet)	2	2	
Sprycel (Tablet)	5	5	PA,QL
Stiolto Respimat (Aerosol Solution)	3	3	QL
Suboxone (Film)	4	4	QL
Sucralfate (Tablet)	2	2	
Sulfamethoxazole/Trimethoprim DS (Tablet)	2	2	
Sulfasalazine (500mg Tablet Delayed-Release, 500mg Tablet Immediate-Release)	2	2	
Sumatriptan Succinate (100mg Tablet, 25mg Tablet, 50mg Tablet)	2	2	QL
Suprax (100mg Tablet Chewable, 200mg Tablet Chewable)	3	3	
Suprax (400mg Capsule, 500mg/5ml Suspension)	3	3	
Symbicort (Aerosol)	3	3	QL
Synjardy (Tablet)	3	3	QL
Synthroid (Tablet)	3	3	
T			
Tamoxifen Citrate (Tablet)	2	2	
Tamsulosin HCl (Capsule)	2	2	
Targretin (1% Gel)	5	5	PA
Tasigna (Capsule)	5	5	PA,QL
Tecfidera (Capsule Delayed-Release)	5	5	QL,LA
Telmisartan (Tablet)	3	3	QL
Telmisartan/Hydrochlorothiazide (Tablet)	3	NC	QL

Pr = AARP® MedicareRx Preferred

Sp = AARP® MedicareRx Saver Plus

NC = Not covered

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Drug Name	Pr	Sp	Requirements
Temazepam (15mg Capsule, 30mg Capsule)	2	2	QL
Tenofovir Disoproxil Fumarate (Tablet)	5	5	QL
Terazosin HCl (Capsule)	2	2	
Testosterone (25mg/2.5gm 1% Gel, 50mg/5gm 1% Gel)	3	3	
Testosterone Cypionate (Injection)	4	4	
Testosterone Pump (1% Gel)	3	3	
Theophylline (Oral Solution)	2	NC	
Theophylline CR, Theophylline ER (Tablet)	2	2	
Timolol Maleate Ophthalmic Gel Forming (Solution) (Generic Timoptic-XE)	3	3	
Tivicay (25mg Tablet, 50mg Tablet)	5	5	QL
Tizanidine HCl (2mg Tablet, 4mg Tablet)	2	2	
Tobramycin Sulfate (0.3% Ophthalmic Solution)	2	2	
Tobramycin Sulfate (10mg/ml Injection, 80mg/2ml Injection)	4	4	
Tobramycin/Dexamethasone (Ophthalmic Suspension)	3	3	
Topiramate (Tablet, Capsule Sprinkle Immediate-Release)	2	2	
Toujeo SoloStar (Injection)	3	3	
Tradjenta (Tablet)	4	3	QL
Tramadol HCl (Tablet Immediate-Release)	2	2	7D,DL,QL,MME
Tranexamic Acid (Tablet)	3	3	
Travatan Z (Ophthalmic Solution)	3	NC	
Trazodone HCl (300mg Tablet)	2	NC	
Trazodone HCl (50mg Tablet, 100mg Tablet, 150mg Tablet)	2	1	
Trelegy Ellipta (Aerosol Powder)	3	NC	QL
Tresiba FlexTouch (Injection)	3	NC	
Tretinoin (0.01% Gel, 0.025% Gel, 0.025% Cream, 0.05% Cream, 0.1% Cream)	4	4	PA
Tretinoin (10mg Capsule)	5	5	
Triamcinolone Acetonide (55mcg/act Aerosol)	4	4	
Triamcinolone Acetonide (Cream, Ointment)	2	2	
Triamcinolone Acetonide (Lotion)	3	3	
Triamterene/Hydrochlorothiazide (37.5mg-25mg Capsule, 50mg-25mg Capsule, 37.5mg-25mg Tablet, 75mg-50mg Tablet)	2	2	

Bold type = Brand name drug Plan type = Generic drug

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Drug Name	Pr	Sp	Requirements
Trihexyphenidyl HCl (0.4mg/ml Elixir, 2mg Tablet, 5mg Tablet)	2	2	
Trintellix (Tablet)	4	4	QL
Trulicity (Injection)	3	3	QL
Truvada (Tablet)	5	5	QL
Tymlos (Injection)	5	5	PA,QL
U			
Uloric (Tablet)	3	3	ST
Ursodiol (250mg Tablet, 500mg Tablet)	4	4	
Ursodiol (300mg Capsule)	3	3	
V			
Valacyclovir HCl (Tablet)	3	2	QL
Valganciclovir (Tablet)	5	5	QL
Valproic Acid (250mg Capsule, 250mg/5ml Oral Solution)	2	2	
Valsartan (Tablet)	2	2	QL
Valsartan/Hydrochlorothiazide (Tablet)	2	2	QL
Vascepa (Capsule)	4	4	
Velphoro (Tablet Chewable)	4	4	
Verapamil HCl (Capsule Extended-Release)	3	NC	
Verapamil HCl (Tablet Immediate-Release, Tablet Extended-Release)	2	2	
Versacloz (Suspension)	5	5	
Vesicare (Tablet)	3	3	QL
Victoza (Injection)	3	NC	QL
Viibryd (Tablet)	4	4	QL
Vimpat (Tablet, 10mg/ml Oral Solution)	4	4	QL
Viread (150mg Tablet, 200mg Tablet, 250mg Tablet, 40mg/gm Powder)	5	5	QL
Vosevi (Tablet)	5	5	PA,QL
Vyvanse (10mg Capsule, 20mg Capsule, 30mg Capsule, 40mg Capsule, 50mg Capsule, 60mg Capsule, 70mg Capsule, 10mg Tablet Chewable, 20mg Tablet Chewable, 30mg Tablet Chewable, 40mg Tablet Chewable, 50mg Tablet Chewable, 60mg Tablet Chewable)	4	NC	

Pr = AARP® MedicareRx Preferred

Sp = AARP® MedicareRx Saver Plus

NC = Not covered

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Drug Name	Pr	Sp	Requirements
W			
Warfarin Sodium (Tablet)	1	1	
X			
Xarelto (Tablet)	3	3	QL
Xigduo XR (Tablet Extended-Release 24 Hour)	NC	3	QL
Xiidra (Ophthalmic Solution)	4	4	QL
Xolair (Injection)	5	5	PA,LA
Xtampza ER (Capsule Extended-Release 12 Hour Abuse-Deterrent)	NC	3	
Xtandi (Capsule)	5	5	PA,QL,LA
Z			
Zafirlukast (Tablet)	3	2	QL
Zaleplon (Capsule)	3	3	QL
Zenpep (Capsule Delayed-Release)	3	3	
Zioptan (Ophthalmic Solution)	NC	4	
Zirgan (Gel)	4	4	
Zolpidem Tartrate (10mg Tablet Immediate-Release, 5mg Tablet Immediate-Release)	2	2	QL
Zonisamide (Capsule)	2	2	

Bold type = Brand name drug Plan type = Generic drug

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Alternative Covered Drugs

Your plan has a long list of covered drugs, but it doesn't cover all drugs. Drugs not covered by your plan typically have alternative drugs that can be used instead. This is a **partial list** of drugs that aren't covered and the alternative covered drug.

Talk with your doctor or pharmacist to see if the alternative drugs listed here are appropriate for you.

PDP Preferred

Drugs not covered by the plan	Alternative covered drugs – Tier
Amlodipine/Benazepril	Amlodipine – 1 Benazepril – 1
Armodafinil	Modafinil – 4 (PA Required)
Carisoprodol	Cyclobenzaprine 5mg and 10mg – 2 Tizanidine Tablet – 2
Cymbalta	Duloxetine – 2
Diovan	Valsartan – 2
Farxiga	Invokana – 3 Jardiance – 3
Lansoprazole	Omeprazole – 2 Pantoprazole Tablet – 2 Rabeprazole Tablet – 2 Nexium Capsule – 3
Lexapro	Escitalopram – 2
Lidoderm	Lidocaine Patch – 4 (PA Required)
Lipitor	Atorvastatin – 1
Metaxalone	Cyclobenzaprine 5mg and 10mg – 2 Tizanidine Tablet – 2
Methocarbamol	Cyclobenzaprine 5mg and 10mg – 2 Tizanidine Tablet – 2
Movantik	Lactulose – 2 Amitiza – 3
Novolin	Humulin – 3
Novolog	Humalog – 3
Nystatin/Triamcinolone	Nystatin – 2 Triamcinolone Cream/Ointment – 2
Otezla	Enbrel – 5 (PA Required) Humira – 5 (PA Required) Remicade – 5 (PA Required)
Plavix 75mg	Clopidogrel 75mg – 2

Bold type = Brand name drug Plain type = Generic drug

Drugs not covered by the plan	Alternative covered drugs – Tier
Proventil HFA	Proair HFA – 3
Qvar	Arnuity Ellipta – 3 Flovent HFA – 3
Risedronate Sodium	Alendronate Tablet – 1 Ibandronate Tablet – 3 Binosto – 4
Temazepam 7.5mg and 22.5mg	Temazepam 15mg or 30mg – 2
Tolterodine	Oxybutynin
Toprol XL	Metoprolol Extended Release – 2
Toviaz	Myrbetriq – 3 Oxybutynin Extended Release – 3 Vesicare – 3 Tolterodine Extended Release – 4
Tudorza Pressair	Incruse Ellipta – 3 Spiriva – 3
Vagifem	Premarin Cream – 3 Estrace Cream – 4 Estring – 4
Vytorin	Ezetimibe – 2 Simvastatin – 1
Xopenex HFA	Proair HFA – 3
Zolpidem Tartrate Extended Release	Zolpidem Immediate Release – 2 Zaleplon – 3 Belsomra – 3 Trazodone – 2

Bold type = Brand name drug

Plain type = Generic drug

Saver Plus

Drugs not covered by the plan	Alternative covered drugs – Tier
Advair Diskus	Breo Ellipta – 3 Symbicort – 3
Amitiza	Linzess – 3
Bystolic	Atenolol – 1 Bisoprolol – 2 Carvedilol Immediate Release Tablet – 1 Metoprolol Succinate Tablet – 1
Celecoxib	Meloxicam Tablet – 1 Naproxen Immediate Release – 2
Cialis 2.5mg and 5mg (BPH use only)	Alfuzosin Extended Release – 2 Doxazosin – 2 Tamsulosin – 2 Terazosin – 2
Clobetasol Propionate	Augmented Betamethasone – 2 Halobetasol – 4
Dexilant	Omeprazole – 2 Pantoprazole Tablet – 2
Dulera	Breo Ellipta – 3 Symbicort – 3
Effient	Clopidogrel 75mg Tablet – 2 Brilinta – 4
Esomeprazole Magnesium	Omeprazole – 2 Pantoprazole Tablet – 2
Eszopiclone	Zolpidem Immediate Release – 2 Trazodone 50mg, 100mg 150mg Tablet – 1 Zaleplon – 3 Belsomra – 3
Famotidine	Ranitidine Tablet – 2 Nizatidine Capsule – 2
Fenofibrate	Fenofibrate 54mg and 160mg Tablet – 2 Gemfibrozil – 2
Invokana	Metformin Immediate Release and Extended Release (Generic Glucophage XR) – 1 Farxiga – 3 Jardiance – 3
Janumet	Jentadueto – 3 Kombiglyze – 3

Bold type = Brand name drug

Plain type = Generic drug

Drugs not covered by the plan	Alternative covered drugs – Tier
Januvia	Metformin Immediate Release and Extended Release (Generic Glucophage XR) – 1 Onglyza – 3 Tradjenta – 3
Lansoprazole	Omeprazole – 2 Pantoprazole Tablet – 2
Levemir	Lantus – 3 Toujeo – 3
Lumigan	Latanoprost – 1
Nexium	Omeprazole – 2 Pantoprazole Tablet – 2
Olmesartan	Losartan – 1 Irbesartan – 2 Valsartan – 2
Potassium Chloride Extended Release Capsule	Potassium Chloride Extended Release Tablet – 2
Proair HFA	Ventolin HFA – 3
Quetiapine Extended Release	Quetiapine Immediate Release Tablet – 2
Qvar	Pulmicort Inhaler – 3
Temazepam 7.5mg and 22.5mg	Temazepam 15mg and 30mg – 2
Travatan Z	Latanoprost – 1
Zolpidem Tartrate Extended Release	Zolpidem Immediate Release – 2 Trazodone 50mg, 100mg, 150mg Tablet – 1 Zaleplon – 3 Belsomra – 3

Bold type = Brand name drug

Plain type = Generic drug

Note: Alternatives are suggestions only and may or may not be appropriate depending on the specific illness being treated. Information is accurate as of August 1, 2018 and may be subject to change. Please refer to formulary materials for details on drug coverage.

The formulary may change at any time. You will receive notice when necessary.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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Ready to Enroll

How to enroll

You can enroll by phone, online, by mail or fax. Simply choose the way that is easiest for you and follow the directions below.



By phone

Call one of our Sales Representatives toll-free at **1-888-867-5564, TTY 711** during 8 a.m. - 8 p.m. local time, 7 days a week to enroll over the phone.



Online

Go to **www.AARPMedicarePlans.com** and follow the step-by-step instructions to enroll.



By mail

Fill out the Enrollment Request Form and mail it to:
UnitedHealthcare
3315 Central AVE
Hot Springs, AR 71913



By fax

Fill out the Enrollment Request Form and fax it to:
Fax: 1-501-262-7070

Enrollment Request Form Checkpoints

✓ Print your name exactly as it appears on your red, white and blue Medicare card	✓ Sign and date where indicated
✓ Make sure you have chosen the plan type that works best for you	✓ Verify your Date of Birth
✓ Make sure your permanent address is correct	✓ Verify your providers accept the plan you are choosing
	✓ Use the drug list to be sure your drugs are covered

Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative:**

- ☐ Medicare Advantage Plans (Part C) and Cost Plans
- ☐ Dental-Vision-Hearing Products
- ☐ Stand-alone Medicare Prescription Drug Plan (Part D)
- ☐ Hospital Indemnity Products
- ☐ Medicare Supplement (Medigap) Plans

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They do NOT work directly for the federal government.

Signing this form does NOT affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature of applicant/member/authorized representative	Today's Date
	MM / DD / YYYY

If you are the authorized representative, please sign above and print clearly and legibly below:

Name (First_Last)	Relationship to Beneficiary
-------------------	-----------------------------

To be completed by Licensed Sales Representative (please print clearly and legibly)

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone - - - - -	Licensed Sales Representative ID
Beneficiary Name (First_Last)	Beneficiary Phone - - - - -	Date Appointment will be Completed MM / DD / YYYY

Beneficiary Address

Initial Method of Contact	Plan(s) the Licensed Sales Representative will Represent During the Meeting
---------------------------	---

Licensed Sales Representative Signature

Agent: Fax completed form to 1-866-994-9659

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-For-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare HMO Point-of-Service (HMO-POS) Plans — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Other Related Products

Dental/Vision/Hearing Products — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.

Hospital Indemnity Products — Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products — Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and coinsurance amounts for Medicare approved services.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare.

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2019 Enrollment Request Form

Please contact the plan if you need this information in another language or an accessible format (Braille).

Please check the plan you want:

☐ **AARP MedicareRx Saver Plus (PDP) K**

☐ **AARP MedicareRx Preferred (PDP) A**

Please Read This Important Information

This is a Part D plan. It's designed to help pay the cost of prescription drugs. **Note:** If you have a Medicare Advantage plan:

- ☐ You may already have drug coverage
- ☐ You will lose that plan automatically when you sign up for a Part D plan. This means you would lose your medical coverage. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan. If you have an MA-only PFFS plan, you may still enroll in a PDP and will not lose your MA-only PFFS plan.

If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union coverage if you join this plan. Read the communication your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Information about you.

Please type or print in black or blue ink.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last Name	First Name	Middle Initial
Birth Date MM - DD - YYYY		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Daytime Phone Number () —		Mobile Phone Number: () —	

Enrollee Name _____

Agent Name / ID No. _____

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Permanent Residence Street Address (P.O. Box is not allowed)			
City	County	State	ZIP Code
Mailing Address (only if it's different from above. You can give a P.O. Box.)			
City	County	State	ZIP Code
E-mail Address			

To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (Explanation of Benefits, Annual Notice of Changes, and other wellness information) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

Check here to opt out of paperless delivery.

- ☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time. We will only use your email address if you change delivery preference or if we have other information to share with you.

Information about your Medicare

Please take out your red, white and blue Medicare card to complete this section.

<input type="checkbox"/> Fill out this information as it appears on your Medicare card.	Name (as it appears on your Medicare card): _____
-OR-	
<input type="checkbox"/> Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Medicare Number: _____
	Sex: _____
	Is Entitled to _____ Effective Date _____
	Hospital (Part A) _____ MM - DD - YYYY
	Medical (Part B) _____ MM - DD - YYYY
	You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

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How do you want to pay?

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. You can also pay from your bank account through Electronic Funds Transfer (EFT), online or by mail.

This plan has a premium (monthly payment). Please choose how you want to pay it. Note: If you have a late enrollment penalty (LEP), we'll add it to your premium.

If you don't choose an option, we'll send a bill each month to your mailing address.

☐ I want to pay from my Social Security or Railroad Retirement Board (RRB) check.

I get monthly benefits from: ☐ Social Security ☐ RRB

We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or there is a delay in setup, we will send you a paper bill for your monthly premiums.

☐ I want to pay directly from a bank account.

- ☐ Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.
- ☐ Please read the statement below.

My bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). My bank will pay the funds from my checking or savings account on or about the fifth of each month. The charges may include up to \$200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from my account, I will tell both UHIC and my bank. I will give them a reasonable amount of time to change my method of payment.

Account Type ☐ Checking ☐ Savings

Account Holder Name _____

Bank Routing Number

Bank Account Number

Signature _____ Date MM - DD - YYYY

☐ I want to pay by mail.

We'll send a bill to your mailing address each month or you will receive an email notification if you signed up for e-delivery.

Enrollee Name _____

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☐ **I want to pay online.**

Visit www.AARPMedicarePlans.com to make a payment directly from a bank account.

If you want to pay by credit card.

After you become a member, you can call us to have your monthly payment charged to your Visa or Mastercard. Until then, we'll send you a bill each month.

A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

Social Security (SS) will send you a letter and ask you how you want to pay it:

- ☐ You can pay it from your SS check
- ☐ Medicare can bill you
- ☐ The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?

If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only part of your premium, we will bill you for the amount that Medicare doesn't cover.

For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

A few questions to help us manage your plan.

1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☐ No

Please check what you'd like: ☐ Spanish ☐ Other _____

If you don't see the language or format you want, please call us toll-free at 1-888-867-5564, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.AARPMedicarePlans.com for online help.

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2. Do you live in a nursing home or a long-term care facility? ☐ Yes ☐ No

If yes, please give us information on the long-term care facility:

Name			
Address	City	State	ZIP Code
Phone Number () -	Date you moved there MM - DD - YYYY		

3. Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No

(Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.)

If yes, what is it?

Name of Other Insurance		
Member Number	Group Number	Date Plan Started MM - DD - YYYY

Please read and sign

By completing this form, I agree to the following:

- ☐ This is a Medicare Prescription Drug plan. It has a contract with the federal government. This Prescription Drug coverage is in addition to Original Medicare. This is not a Medicare Supplement plan.
- ☐ I need to keep my Medicare Parts A or B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- ☐ I can only be in one Medicare Prescription Drug plan at time-if I am currently in a Medicare Prescription Drug plan, my enrollment in this plan will end that enrollment.
- ☐ If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- ☐ I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so between October 15 and December 7. This is the Open Enrollment Period for Medicare Advantage **and** Medicare prescription drug coverage. I understand that there may be special situations at other times during the year in which I can leave the plan.
- ☐ This plan covers a specific area. If I plan to move out of the area, I will call my plan to switch to a plan in the new area. Medicare may not cover me when I'm out of the country. However, I have some limited coverage near the U.S. border. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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- ☐ I will receive information on how to get an Evidence of Coverage. (The EOC is also known as a member contract or subscriber agreement.) The EOC will list services the plan covers, as well as the plan's terms and conditions. The plan will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by the plan, Medicare and the plan won't pay for it. If I disagree with how the plan covers my care, I have the right to make an appeal.
- ☐ I understand I must use network pharmacies except in an emergency. I have the right to make an appeal if I disagree with how the plan covers or pays for services.
- ☐ My plan will give my information, including my prescription drug event data, to Medicare and other plans when needed for treatment, payment and health care operations. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- ☐ I understand that my state may offer help and advice with Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.
- ☐ If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- ☐ The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose the plan.

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and you have received your UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file.

Signature of Applicant/Member/Authorized Representative

Today's Date

MM - DD - YYYY

Enrollee Name _____
Y0066_PDP180607_021155 Approved AAEX19PD4314357_000

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Ready to Enroll

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If you are the authorized representative, please sign above and complete the information below.
***NOT A SALES AGENT**

Last Name		First Name	
Address			
City		State	ZIP Code
Phone Number () -		Relationship to Applicant	

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<input type="checkbox"/> New Member	Employer Group Name
<input type="checkbox"/> Plan Change	

Sales Representative/Writing ID	Initial Receipt Date MM - DD - YYYY
---------------------------------	--

Sales Representative/Agent Name	Proposed Effective Date MM - DD - YYYY
---------------------------------	---

Sales Representative Phone Number () –

☐ National Retail/Mall Program ☐ Local Event Outreach ☐ Appointment ☐ Other

☐ Member Meeting ☐ Community Meeting ☐ Walmart Program

How was this application submitted? ☐ Mail ☐ Fax ☐ Online

☐ AEP
 ☐ IEP
 ☐ IEP 2
☐ SEP (Institutional)
 ☐ SEP (Dual Eligible)
 ☐ SEP - GEP Part B
☐ SEP (SEP Reason) _____
☐ SEP Eligibility Date MM - DD - YYYY

Date: MM - DD - YYYY

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (聽力語言殘障服務專線 TTY : 711).

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Plan Recap

We want to make sure you know what to expect with the new plan you've chosen.

✓ Fill out this plan recap with your Sales Representative (if applicable). It will take you through some plan details to help you better understand your new plan.

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PLAN INFORMATION Here are some details about your plan and coverage.

My new plan is a Medicare Part D Plan.

The name of my new plan is: _____

Proposed effective date: **M M / D D / Y Y Y Y**

I must have Medicare Part A and/or Part B to enroll in this plan.

I can cancel my enrollment in this plan before my coverage starts by calling Customer Service at _____. Once my coverage starts, I may have to wait until I have a valid election period to make a plan change.

My plan (circle one): **DOES / DOES NOT** have a deductible.

If I have a deductible it applies to drugs in (check the answer(s)):

☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Tier 4 ☐ Tier 5 or ☐ ALL tiers

I must live in the plan's service area, which is _____. I will need to choose a new plan if I move outside of the service area for more than 6 months in a row.

I cannot have a stand-alone Medicare Part D plan and a Medicare Advantage plan at the same time. (Unless my Medicare Advantage plan is a Private Fee-for-Service plan that doesn't have prescription drug coverage.)

\$

PREMIUM INFORMATION What you need to know about paying your monthly plan premium.

My plan has a \$ _____ monthly premium that I must pay to stay in this plan. In addition, I must remain enrolled in Medicare Part A and/or Part B and if I have Part B, I must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me.

If I owe a Late Enrollment Penalty (LEP), it is not included in my premium. I will need to add it to my premium each month.



PRESCRIPTION DRUG COVERAGE Know what is covered by your prescription drug plan.

Medication	Tier Level ¹	Has Limits ² (Yes/No)

My current pharmacy is _____. I understand that preferred network pharmacies tend to offer lower prescription drug costs.

I (circle one) **DO / DO NOT** have drugs that are not on the covered drug list (formulary).
My drugs that are not on the formulary are _____ and _____.
I can discuss alternatives by calling customer service or checking with my doctor or pharmacist.

- I understand how my prescription drug plan works, including:
- The cost difference between preferred network, standard network and out-of-network pharmacies
 - Tier levels
 - Prior authorizations
 - Quantity limits
 - Step therapy
 - Drug coverage stages and how they impact my costs
 - Late Enrollment Penalty

- I have the option to access my plan documents, such as Explanation of Benefits (EOB), electronically.
- ☐ I have opted to access documents electronically.
- ☐ I have not opted to access documents electronically at this time, but can contact the plan in the future to activate this option.
- ☐ I have provided an email address to provide the plan with various ways to reach me regarding important information.
- ☐ I do not have an email address; should I get one in the future I can provide it to the plan to provide other ways to reach me with important information.

Contact your Sales Representative

If I have questions, I will call my Sales Representative, _____ at _____ or Customer Service at _____.

¹My actual out of pocket costs may vary based on: the drug stage I am in, my drug tier level, the pharmacy I use (retail/mail-order), and if I have Extra Help.

²For medications that have limitations, I may need to contact the plan before I can fill my prescription.

Y0066_180625_114748 Accepted AAEX19PD4305572_000

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2019 Enrollment Receipt

To be completed if enrolling with a Sales Representative.

Please use this as your Temporary Proof of Coverage until Medicare has confirmed your enrollment, and you receive your UnitedHealthcare® member ID card. This receipt is not a guarantee of enrollment.

This copy is for your records only. Please do not resubmit enrollment.

Applicant 1:

Name

Application DateMM / DD / YYYY

Proposed Effective DateMM / DD / YYYY

Plan Name

Plan Type

Enrollment Tracking No. (if applicable)

Call your Sales Representative if you have any questions:

Sales Representative Name and ID Number

Sales Representative Phone No.

RxBIN: 610097

Rx PCN: 9999

RxGRP: PDPIND

We're here to help. If you have additional questions you can call Customer Service toll-free at 1-888-867-5564, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.



Ready to Enroll

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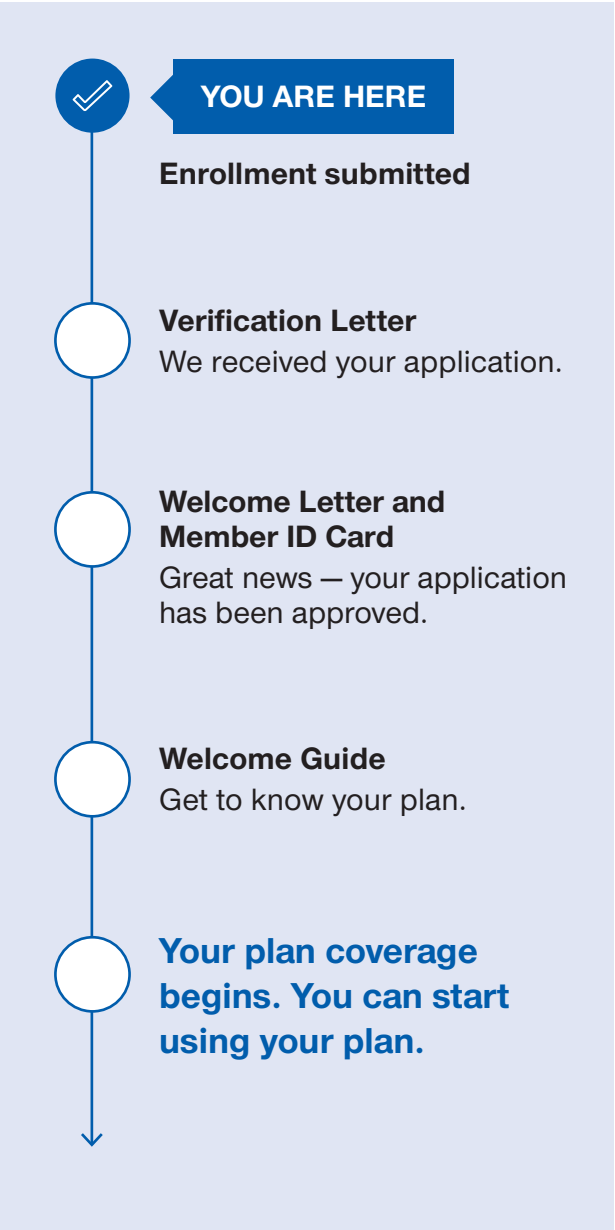
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Here's What You Can Expect Next

We want to help you take advantage of everything your plan has to offer. Keep this page and track your progress as you go. We'll be here to help every step of the way.


TEAR HERE





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Get ready to use your plan to your advantage

Below are some helpful savings options for when your plan coverage begins:

 **Learn about and sign up for prescription home delivery.** Once your coverage begins, sign up and save by having your 3-month supply of medication conveniently mailed to your home.

 **Take advantage of members-only savings at preferred retail pharmacies.** Get extra savings by filling your prescriptions through our Preferred Retail Pharmacy Network.

 **Review your drugs with your doctor.** Bring a list of all the drugs you are currently taking with you to your doctor's appointments. Ask about generic drugs and lower-cost options that may be available to you and if they might work for you.

Thank you for choosing UnitedHealthcare®

When you receive your UnitedHealthcare member ID card you can use it to register online at **myAARPMedicare.com**. After you register you can find pharmacies in your area, view plan documents and review your drug list (Formulary). If you have any questions, you can call the Customer Service number on the back of your member ID card.

Questions? We're here to help.



For additional information, please contact the plan or your Sales Representative.



1-888-867-5564, TTY 711
8 a.m. - 8 p.m. local time, 7 days a week



Learn more online at
www.AARPMedicarePlans.com