

# PLAN SELECTION FORM

Date:

Member Name:

Member Number:

I want to transfer from my current Part D plan to the Part D plan I have selected below effective 1/1/2021.

Please check the appropriate box below:

**Elixir RxPlus**

Monthly premium amount: See Benefit Summary attached

Deductible: \$445

Deductible Tiers: 3, 4, 5

Copay: See Benefit Summary attached

## Your Plan Premium

**You can pay your monthly plan premium by mail, online at [www.elixirinsurance.com](http://www.elixirinsurance.com) each month or by automatic deduction from your Social Security/Railroad Retirement Board benefit check each month.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

**If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. DON'T pay Elixir Insurance the Part D-IRMAA extra amount.**

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. If you don't select a payment option, you will receive a bill each month.

**Please select a premium payment option:**

- Receive a bill
- Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check
- I get monthly benefits from:  Social Security  Railroad Retirement Board

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

- Spanish
- Large Print

Please contact Elixir Insurance at 877-583-2617 (TTY users should call 711) if you need information in an accessible format or language other than what is listed above. Our office hours are 24 hours a day, 7 days a week.

Signature: _____	Today's Date: _____
If you are the authorized representative, you must sign above and provide the following information:	
Name: _____	
Address: _____	
Phone Number: (_____) _____ - _____	
Relationship to Enrollee _____	

Please mail this form to:

**ELIXIR INSURANCE**  
**SUITE 201**  
**2181 EAST AURORA ROAD**  
**TWINSBURG OH 44087**



**2021 Summary of Benefits**  
**\$14.30-\$15.60 Monthly Plan Premium**

**Elixir RxPlus**  
 A Medicare Approved Prescription Drug Plan

PLAN PREMIUM	PLAN DEDUCTIBLE
<b>\$14.30</b> (CT, GA, IN, KY, MA, ME, MS, NC, NH, OR, RI, VA, VT, WA ) <b>\$15.10</b> (AL, CA, DE, DC, MD, TN, TX ) <b>\$15.60</b> (MI, NY, OH, PA, SC, WV )	<b>\$0 Deductible on Generic Drug Tiers 1 &amp; 2</b> <b>\$445 Deductible on Drug Tiers 3-5</b>

**INITIAL COVERAGE STAGE**  
 Amount you pay until you and the plan pay a total of \$4,130 (includes deductible) for covered prescription drug expenses.

Tier Number: Name	1-month supply cost share:		2-month supply cost share:		3-month supply cost share:	
	Preferred	Standard	Preferred	Standard	Preferred	Standard
<b>1: Preferred Generic</b>	\$1	\$15	\$2	\$30	\$3 (\$0 mail)	\$45
<b>2: Generic</b>	\$6	\$16	\$12	\$32	\$18 (\$6 mail)	\$48
<b>3: Preferred Brand</b>	\$43	\$47	\$86	\$94	\$129 (\$107.50 mail)	\$141 (\$117.50 mail)
<b>4: Non-Preferred Drug</b>	45%	50%	45%	50%	45%	50%
<b>5: Specialty</b>	25%	25%	N/A	N/A	N/A	N/A

The above are applicable for both retail and mail order pharmacies unless where lower is specified in parentheses (\$). If you reside in a long-term care facility, you pay the same as at a standard pharmacy and may receive up to a 31-day supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

**COVERAGE GAP STAGE** Amount of out-of-pocket costs you pay between \$4,130 and \$6,550 in total prescription drug expenses.

<b>1-month, 2-month or 3-month supply you pay:</b>	
<b>Generic</b>	You pay no more than 25% of the cost
<b>Brand</b>	You pay 25% of the negotiated price & a portion of the dispensing fee

**CATASTROPHIC STAGE** Amount you pay after \$6,550 in annual out-of-pocket covered prescription drug expenses.

<b>1-month, 2-month or 3-month supply you pay:</b>	
<b>Generic</b>	You pay the greater of 5% coinsurance or \$3.70 copay
<b>Brand</b>	You pay the greater of 5% coinsurance or \$9.20 copay

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request an Evidence of Coverage by calling Member Services or visit [elixirsinsurance.com](http://elixirsinsurance.com). Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

To join Elixir RxPlus you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area. We offer coverage in all states, Puerto Rico and Guam. However, there may be cost or other differences between the plans we offer in each state or territory. If you move out of state or territory and into a state or territory that is still within our service area, you must call Member Services in order to update your information.



## 2021 Summary of Benefits

Find premium details by state on the next page.

## Elixir RxSecure

A Medicare Approved Prescription Drug Plan

### DEDUCTIBLE

**\$445**

### COPAYS AND COINSURANCE

#### INITIAL COVERAGE STAGE

Amount you pay until you and the plan pay a total of \$4,130 (includes deductible) for covered prescription drug expenses

	1-month supply you pay:		2-month supply you pay:		3-month supply you pay:	
Drug Coverage Tier Number	Preferred Cost Sharing	Standard Cost Sharing	Preferred Cost Sharing	Standard Cost Sharing	Preferred Cost Sharing	Standard Cost Sharing
Tier 1 – Preferred Generic	\$1	\$18	\$2	\$36	\$3 (Mail \$0)	\$54
Tier 2 – Generic	\$7	\$19	\$14	\$38	\$21 (Mail \$10.50)	\$57
Tier 3 – Preferred Brand	15%	20%	15%	20%	15%	20%
Tier 4 – Non-Preferred Drug	Varies by state. See next page.					
Tier 5 – Specialty	25%	25%	N/A	N/A	N/A	N/A

The above are applicable for both retail and mail-order pharmacies. If you reside in a long-term care facility, you pay the same as at a standard pharmacy and may receive up to a 31-day supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

#### COVERAGE GAP STAGE

Amount of out-of-pocket costs you pay between \$4,130 and \$6,550 in total prescription drug expenses.

#### 1-month, 2-month or 3-month supply you pay:

#### Generic

No more than 25% of the cost

#### Brand

25% of the negotiated price and a portion of the dispensing fee

#### CATASTROPHIC STAGE

Amount you pay after \$6,550 in annual out-of-pocket covered prescription drug expenses.

#### 1-month, 2-month or 3-month supply you pay:

#### Generic

Greater of \$3.70 or 5%

#### Brand

Greater of \$9.20 or 5%

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request an Evidence of Coverage by calling Member Services or visit [elixirinsurance.com](http://elixirinsurance.com). Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

# Premiums and Cost-Share by State\*

# Elixir RxSecure

A Medicare Approved Prescription Drug Plan

STATE	PREMIUM	COPAYS AND COINSURANCE - TIER 4	
		Preferred	Standard
		1-month, 2-month or 3-month supply	
Alabama	\$27.20	34%	39%
California	\$30.80	29%	33%
Connecticut	\$34.40	32%	35%
Delaware	\$29.40	29%	33%
District of Columbia	\$29.40	29%	33%
Georgia	\$26.00	29%	32%
Indiana	\$27.80	33%	37%
Kentucky	\$27.80	33%	37%
Maine	\$28.50	32%	36%
Maryland	\$29.40	29%	33%
Massachusetts	\$34.40	32%	35%
Michigan	\$29.30	34%	37%
Mississippi	\$25.20	29%	32%
New Hampshire	\$28.50	32%	36%
New York	\$35.80	34%	39%
North Carolina	\$26.00	32%	37%
Ohio	\$27.00	34%	37%
Oregon	\$32.50	35%	40%
Pennsylvania	\$35.00	34%	39%
Rhode Island	\$34.40	32%	35%
South Carolina	\$24.80	34%	39%
Tennessee	\$27.20	34%	39%
Texas	\$20.20	33%	37%
Vermont	\$34.40	32%	35%
Virginia	\$26.80	37%	41%
Washington	\$32.50	35%	40%
West Virginia	\$35.00	34%	39%

\*The above coinsurance and copays are applicable for both retail and mail order pharmacies.

To join Elixir RxSecure you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area. We offer coverage in all states, Puerto Rico and Guam. However, there may be cost or other differences between the plans we offer in each state or territory. If you move out of state or territory and into a state or territory that is still within our service area, you must call Member Services in order to update your information.

## 2021 Summary of Benefits, Part D Plan Benefit Reminders

This information is not a complete description of benefits. Call 1-866-250-2005 (TTY: 711) 24 hours a day, 7 days a week for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-250-2005 (TTY: 711) 24 hours a day, 7 days a week. ATENCIÓN: si habla Español, los servicios de asistencia lingüística, sin cargo, están disponibles para usted. Llamada 1-866-250-2005 (TTY: 711) 24 horas al día, 7 días a la semana.

If you want to know more about the coverage and costs of Original Medicare or to compare plans, look in your current “Medicare & You” handbook. You can also view it online at <http://www.medicare.gov>. You can also call 1-800-MEDICARE to order your booklet.

You can see the complete plan formulary (list of Part D covered prescription drugs) and any restrictions, as well as view the pharmacy directory on our website at [elixirinsurance.com](http://elixirinsurance.com). Elixir Insurance is a Prescription Drug Plan with a Medicare contract. Enrollment in Elixir Insurance depends on contract renewal.

If you qualify for Extra Help, you get help paying for any Medicare drug plan’s monthly premium, yearly deductible, and prescription coinsurance. This “Extra Help” also counts toward your out-of-pocket costs. People with limited income and resources may qualify for “Extra Help.” Some people automatically qualify for “Extra Help” and don’t need to apply. Medicare mails a letter to people who automatically qualify for “Extra Help.”

You may be able to get “Extra Help” to pay for your prescription drug premiums and costs. To see if you qualify for getting “Extra Help,” call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778.

Elixir Insurance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Elixir Insurance does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Elixir Insurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services. If you believe that Elixir Insurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Elixir Insurance, mailing address: 2181 E. Aurora Rd, Ste. 201, Twinsburg, OH, 44087, Member Services: 1-866-250-2005, TTY: 711, fax: 1-877-503-7231. If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.