Anthem BlueCross

Medicare Prescription Drug Coverage

Combined Evidence of Coverage and Disclosure Form for the Blue Cross MedicareRx (PDP) Plan with Senior Rx Plus

Effective January 1, 2016

Sponsored by Insurance and Benefits Trust of PORAC
(Peace Officers Research Association of California)

Anthem Blue Cross Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal.

Contracted by the CalPERS Board of Administration Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

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CalPERS

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-866-470-6265**. Someone who speaks English/ Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-866-470-6265**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin:
我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 **1-866-470-6265**。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese:
您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 **1-866-470-6265**。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-866-470-6265**. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-866-470-6265**. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-866-470-6265** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-866-470-6265**. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-866-470-6265** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-866-470-6265**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا.
للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-668-074-5626** سيقوم شخص
بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

Hindi: हमारे सवासथय या दवा की योजना के बारे में आपके किसी भी पशन के जवाब देने के लिए हमारे पास मुफत दुभाषिया सेवाएँ उपलबध हैं. एक दुभायिषा परापत करने के लिए, बस हमें **1-866-470-6265** पर फोन करें. कोई वयकित जो हिनदी बोलता है आपकी मदद कर सकता है. यह एक मुफत सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-866-470-6265**. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-866-470-6265**. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-866-470-6265**. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-866-470-6265**. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-866-470-6265** にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Evidence of Coverage

January 1, 2016 – December 31, 2016

Your Group Sponsored Medicare Prescription Drug Coverage as a Member of Blue Cross MedicareRx (PDP) with Senior Rx Plus

This booklet gives you the details about your Medicare prescription drug coverage and non-Medicare supplemental drug coverage from January 1, 2016 – December 31, 2016. It explains how to get coverage for the prescription drugs you need**. This is an important legal document. Please keep it in a safe place.**

Customer Service:

For help or information, please call Customer Service or go to your plan website.
1-866-470-6265 (Calls to this number are free.)
TTY users: **711**
www.anthem.com/ca

Hours of Operation:

Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays

This plan is offered by Anthem Blue Cross. (When this *Evidence of Coverage* says "we," "us" or "our," it means Anthem Blue Cross. When it says "retiree drug coverage," "the plan", "our plan" or "your plan," it means Blue Cross MedicareRx (PDP) with Senior Rx Plus.)

Our plan has free language interpreter services available to answer questions from non-English speaking members. Please call the Customer Service number listed above to request interpreter services.

This document may be available in large print, Braille or other alternate formats. Please call the Customer Service number listed above for additional information.

Limitations, copayments, and restrictions may apply. Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year or upon renewal. The formulary and pharmacy network may change at any time. You will receive notice when necessary.

Your 2016 Prescription Drug Benefit Chart
10/25/45, $100 Deductible (with Senior Rx Plus)
PORAC
Effective January 1, 2016

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

Formulary	**Open**
Deductible	**$100**
Covered Services	**What you pay**
Part D Initial Coverage	
Below is your payment responsibility from the time you meet your deductible, if you have one, until the amount paid by you and the Coverage Gap Discount Program for covered prescriptions reaches your True Out of Pocket limit of $4,850.	
Retail Pharmacy	per 30-day supply
• Select Generics	$0 copay Deductible waived on Select Generics
• Generics	$10 copay
• Preferred Brands	$25 copay
• Non-Preferred Brands and Non-Formulary Drugs	$45 copay
Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.	
Mail-Order Pharmacy	per 90-day supply
• Select Generics	$0 copay Deductible waived on Select Generics
• Generics	$20 copay
• Preferred Brands	$40 copay
• Non-Preferred Brands and Non-Formulary Drugs	$75 copay
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $4,850.	
• Select Generics	$0 copay
• Generic Drugs	5% coinsurance with a minimum copay of $2.95 and a maximum copay of $10.00

Covered Services	What you pay
• Brand-Name Drugs	5% coinsurance with a minimum copay of $7.40 and a maximum copay of $25.00
Extra Covered Drugs	
These are drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays. These drugs are covered by your Senior Rx Plus benefits.	
Cough and Cold **DESI** **Vitamins and Minerals** **Lifestyle drugs, including Erectile Dysfunction (ED)**	See Formulary for complete list of drugs covered
• Generics	You pay your Retail or Mail-Order copay
• Preferred Brands	You pay your Retail or Mail-Order copay
• Non-Preferred Brands	You pay your Retail or Mail-Order copay
Non-Part D Diabetic Supplies	Lancets, Urine Test Strips and Blood Sugar Diagnostics
• Prescription – Retail Pharmacy	$25 copay
• Prescription – Mail-Order Pharmacy	$40 copay
Non-Part D Diabetic Supplies	Glucometers Copay or coinsurance per Covered Device
• Prescription	$25 copay
Extra Covered Drugs - California	
These are drugs that are covered on retiree drug plans issued in California. These drugs are often excluded from Part D coverage, but are covered by your Senior Rx Plus benefits. If you have a deductible, it does not apply to these drugs.	
Contraceptive Devices	Limit 1 per year; Copay or coinsurance per Covered Device
• Prescription	33% coinsurance

- **Vaccines:** Medicare covers some vaccines under Part B medical coverage and other vaccines under Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever, and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under medical coverage if you fall into a high risk category and under drug coverage for everyone else. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefit chart is the amount you pay for covered drugs filled at network pharmacies.

- Sponsored by Insurance and Benefits Trust of PORAC (Peace Officers Research Association of California)
  Contracted by the CalPERS Board of Administration
  Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

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For more help in finding information you need, go to the first page of a chapter.
You will find a detailed list of topics at the beginning of each chapter.

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Tells you how to get in touch with your plan and with other organizations, including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

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Tells about the stages of drug coverage, including Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage, and how these stages affect what you pay for your drugs. Explains the cost sharing tiers for your Part D drugs, along with the benefit chart located at the front of this booklet, tells you what you must pay as your share of the cost for a drug in each cost sharing tier. Tells about the late-enrollment penalty.

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Tells you, step-by-step, what to do if you are having problems or concerns as a member of our plan.

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CHAPTER 1

Getting started as a member

Getting started as a member

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SECTION 1 Introduction

Section 1.1 You are enrolled in Blue Cross MedicareRx (PDP) with Senior Rx Plus, which is a group sponsored Medicare prescription drug plan with supplemental drug coverage.

You are covered by Original Medicare or another company's Medicare Advantage plan for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through Blue Cross MedicareRx (PDP) with Senior Rx Plus.

There are different types of Medicare plans. Blue Cross MedicareRx (PDP) with Senior Rx Plus is a Medicare prescription drug plan (also called Group Part D or PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company. In addition, your retiree drug coverage includes non-Medicare supplemental drug coverage provided by your Senior Rx Plus benefits.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan. This booklet explains benefits you have under your Group Part D coverage and your non-Medicare supplemental drug coverage. We will refer to your complete drug coverage as your "retiree drug coverage" or "this plan." Your retiree drug coverage includes basic coverage provided by Group Part D and supplemental coverage provided by Senior Rx Plus.

Your Certificate of Coverage for your Senior Rx Plus plan benefits will explain in more detail how these supplemental benefits work.

The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of Blue Cross MedicareRx (PDP) with Senior Rx Plus.

It's important for you to learn what your plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned, or just have a question, please contact your plan's Customer Service. Phone numbers are printed on the back cover of this booklet.

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how your plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The benefits described in this *Evidence of Coverage* are in effect during the months listed on the first page, as long as you are a validly enrolled member in this plan.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of your plan after December 31, 2016, or on your group sponsored plan's renewal date. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2016.

Medicare must approve your plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve your plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You are eligible for coverage under your (or your spouse's) group sponsored health plan retiree benefits. If you have questions regarding your eligibility for coverage under your (or your spouse's) group sponsored retiree benefits, please contact the group's benefit administrator.
- You live in the service area in which we can provide retired group members access to network pharmacies, which includes the 50 United States, District of Columbia (D.C.), and all U.S. Territories, except the U.S. Virgin Islands, and you have Medicare Part A or Medicare Part B (or you have both Part A and Part B) (section 2.2 tells you about Medicare Part A and Medicare Part B).

Section 2.2 What are Medicare Part A and Medicare Part B?

As discussed in section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through our plan. We describe the drug coverage you receive under your Medicare Part D coverage in Chapter 3.

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals for inpatient services, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, (such as physicians' services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the service area for your plan

Although Medicare is a federal program, your plan is available only to individuals who live in the service area. To remain a member of our group sponsored plan, you must continue to reside in one of the 50 United States, or the District of Columbia (D.C.), or one of the U.S. Territories, excluding the U.S. Virgin Islands, which is our Medicare-defined service area. We cannot service retirees or their dependents if they live outside the service area.

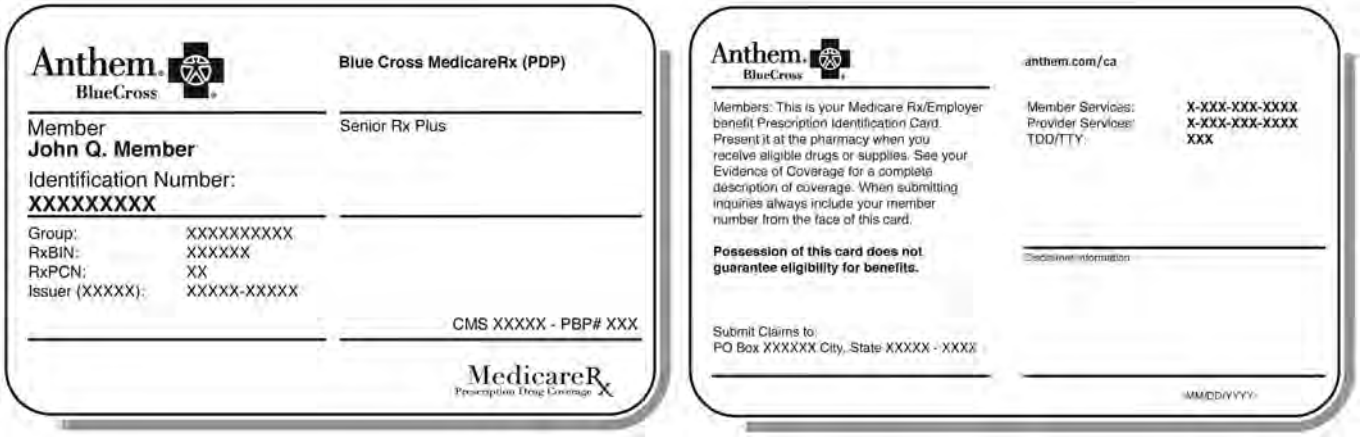
If you plan to move out of the service area, please contact all of the following to update your contact information:

- Customer Service (phone numbers are printed on the back cover of this booklet).
- Former employer or union (group sponsor) of your group plan.
- Social Security. You can find their phone numbers and contact information in Chapter 2, Section 5.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your membership card for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost or stolen, call Customer Service right away and we will send you a new card. Phone numbers for Customer Service are printed on the back cover of this booklet.

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network

What are "network pharmacies?"

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for plan members.

Your Group Part D and Senior Rx Plus coverage use the same network pharmacies.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. You can call Customer Service for updated provider information or ask us to mail you a *Pharmacy Directory*. **Please review your *Pharmacy Directory* to see which pharmacies are in our network.**

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service. Phone numbers are printed on the back cover of this booklet. At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website.

Section 3.3 Your plan's *List of Covered Drugs (Formulary)*

Your plan has a *List of Covered Drugs (Formulary)*. We call it the *"Drug List"* for short. It tells which Part D prescription drugs are covered by your plan. The drugs on this list are selected by us with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved this plan's *Drug List*.

The *Drug List* also tells you if there are any rules that restrict coverage for your drugs.

We'll send you a copy of the *Drug List*. To get the most complete and current information about which drugs are covered, you can call Customer Service. Phone numbers are printed on the back cover of this booklet.

Section 3.4 The *Part D Explanation of Benefits* (the "*Part D EOB*"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "*Part D EOB*").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount your retiree drug coverage has paid for each of your Part D prescription drugs during the month. Chapter 4, "What you pay for your Part D prescription drugs," gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service.

SECTION 4 Your monthly premium

Section 4.1 How much is your plan premium?

Your (or your spouse's) coverage is provided through a contract with your (or your spouse's) former group, employer or union. Please contact the group's benefits administrator for information about your plan premium.

In some situations, your plan premium could be less.

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, we will send you a separate insert, called the *"Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"* (also known as the *"Low Income Subsidy Rider"* or the *"LIS Rider"*), which tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the *"LIS Rider."* Phone numbers for Customer Service are printed on the back cover of this booklet. Or, if you are a member of a State Pharmaceutical Assistance Program (SPAP) and they are helping with your premium costs, please contact your SPAP to determine what help is available to you. For contact information, please refer to the state specific agency listing located in Chapter 11.

In most cases, because you're enrolled in a group sponsored plan, we'll credit the amount of "Extra Help" received to your group's bill on your behalf. If your group plan pays 100% of the premium for your retiree coverage, then they are entitled to keep these funds. However, if you contribute to the premium, your group must apply the subsidy toward the amount you contribute to this plan.

In some situations, your plan premium could be more.

In some situations, you may owe additional money because of your income or when you enrolled in Part D. Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. "Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. For these members, the late enrollment penalty is added to the plan's monthly premium. For members of group sponsored plans, this amount is usually added to the premium charged to the group, unless you are normally billed directly by your plan.

- If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you

were without drug coverage after you became eligible. Chapter 4, Section 10 explains the late enrollment penalty.

- If you think that you may have a late enrollment penalty, you may want to contact your (or your spouse's) group's benefits administrator or Customer Service (phone numbers are printed on the back cover of this booklet) to find out what you will have to pay toward the penalty.
- If you have a late enrollment penalty and do not pay it, you could be disenrolled from your plan.

Many members are required to pay other Medicare premiums.

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B.

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from your plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 4, Section 11 of this booklet. You can also visit **www.medicare.gov** on the web or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or you may call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**.

Your copy of *Medicare & You 2016* gives information about the Medicare premiums in the section called "2016 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2016* from the Medicare website (**www.medicare.gov**). Or you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users, call **1-877-486-2048**.

Section 4.2 Can we change your monthly plan premium during the year?

Generally, your plan premium won't change during the benefit year. You will be notified in advance if there will be any changes for the next benefit year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If you qualify for the "Extra Help" program for your prescription drug costs, the "Extra Help" program will pay part of your monthly plan premium. If you lose eligibility during the year, you will need to start paying the full monthly premium.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in your plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered and the cost sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your group, your spouse's group, workers' compensation or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Customer Service. Phone numbers are printed on the back cover of this booklet. Please remember to also notify your former employer or union (group sponsor) of your group plan so they will have your most up-to-date contact information on file.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any medical or drug insurance coverage that you have in addition to this retiree drug coverage. That's because we must coordinate any other coverage you have with your benefits under this plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need

to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. Phone numbers are printed on the back cover of this booklet.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance, there are rules set by Medicare that decide which of your insurance plans pays first and which pays second or even third. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. This retiree drug coverage includes basic coverage provided by Group Part D benefits and additional coverage provided by your Senior Rx Plus supplemental benefits.

Your Group Part D and Senior Rx Plus coverage always work together so that you pay the copayment or coinsurance shown in the benefit chart located at the front of this booklet when you get covered drugs at a network pharmacy. Between these two coverages, Group Part D makes the primary payment and Senior Rx Plus makes secondary payments for all Part D eligible drugs. Additionally, if your plan covers drugs beyond those covered by Medicare (we call these drugs "Extra Covered Drugs"), your Senior Rx Plus coverage will make the primary payment for these drugs.

If you have another group sponsored health plan in addition to this plan, the following rules will be used to determine whether this retiree drug coverage or your other coverage pays first:

- If you have retiree coverage, Medicare pays first.
- If your group sponsored health plan coverage is based on your current employment or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or end-stage renal disease (ESRD):

  - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the group has 100 or more employees or at least one group in a multiple group sponsored plan that has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, your plan pays first if the group has 20 or more employees or at least one group in a multiple group sponsored plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group sponsored health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, group sponsored health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service. Phone numbers are printed on the back cover of this booklet. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

2. Important phone numbers and resources

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SECTION 1 **Your plan contacts** (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	**1-866-470-6265** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Blue Cross MedicareRx (PDP) with Senior Rx Plus P.O. Box 110 Fond du Lac, WI 54936-0110
WEBSITE	www.anthem.com/ca

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."

You only need to request a coverage decision, submit an appeal or a complaint once. We will process your request against both your Group Part D and Senior Rx Plus coverage.

Method	Coverage Decisions – Contact Information
CALL	**1-866-470-6265** Calls to this number are free.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Anthem Blue Cross - Senior Appeals and Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
WEBSITE	www.anthem.com/ca

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."

You only need to request a coverage decision, submit an appeal or a complaint once. We will process your request against both your Group Part D and Senior Rx Plus coverage.

Method	Appeals – Contact Information
CALL	**1-866-470-6265** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Anthem Blue Cross - Senior Appeals and Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
WEBSITE	www.anthem.com/ca

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about your plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."

Method	Complaints – Contact Information
CALL	**1-866-470-6265** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Anthem Blue Cross - Senior Appeals and Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
MEDICARE WEBSITE	You can submit a complaint about your plan directly to Medicare. To submit an online complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**

Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask your plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5, "Asking us to pay our share of the costs for covered drugs."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" for more information.

Method	Payment Requests – Contact Information
CALL	**1-866-470-6265** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Blue Cross MedicareRx (PDP) with Senior Rx Plus P.O. Box 110 Fond du Lac, WI 54936-0110

SECTION 2 **Medicare** (how to get help and information directly from the federal Medicare program)

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare prescription drug plans, including us.

Method	Medicare – Contact Information
CALL	**1-800-MEDICARE**, or **1-800-633-4227**

Method	Medicare – Contact Information
	Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about your plan: • **Tell Medicare about your complaint:** You can submit a complaint about your plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call **Medicare** and tell them what information you are looking for. They will find the information on the website, print it out and send it to you. (You can call **Medicare** at **1-800-MEDICARE**

Method	Medicare – Contact Information
	(1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

SECTION 3 State Health Insurance Assistance Program (free help, information and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. The SHIP program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

The State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

For contact information, please refer to the state-specific agency listing, which is located in the SHIP section of Chapter 11 in this booklet.

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare.

You should contact the Quality Improvement Organization if you have a complaint about the quality of care you have received. For example, you can contact the QIO if you were given the wrong medication or if you were given medications that interact in a negative way. For contact information, please refer to the state-specific agency, which is located in the QIO section of Chapter 11 in this booklet.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end-stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks,

enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	**1-800-772-1213** Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	**www.ssa.gov**

SECTION 6 **Medicaid** (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

For contact information for Medicaid and its programs, please refer to the state-specific agency listing located in Chapter 11 of this booklet.

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, deductible, and prescription copayments. 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 a.m. to 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**; or
- Your State Medicaid Office. (For contact information, please refer to the specific agency listing located in Chapter 11.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may

make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions. Phone numbers are printed on the back cover of this booklet.

There are programs in Puerto Rico, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules. Phone numbers are located in Chapter 11. Or call **1-800-MEDICARE** (**1-800-633-4227**) 24 hours a day, 7 days a week and say "*Medicaid*" for more information. TTY users should call **1-877-486-2048**. You can also visit **www.medicare.gov** for more information.

Medicare Coverage Gap Discount Program

If you are not receiving help to pay your share of drug costs through the Low Income Subsidy (LIS) or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2016, once the cost paid by you and your retiree drug plan reaches $3,310, the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount. The Coverage Gap Discount applies until the cost paid by you and the Discount reaches $4,850. Drug manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. **Please note:** Your retiree drug plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to drugs listed as "Extra Covered Drugs" in your benefits.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills for your prescription and your *Part D Explanation of Benefits (Part D EOB)* will show any discount provided. It will also reflect the coverage provided by your Senior Rx Plus supplemental coverage after the discount is applied. Both the amount you pay and the amount discounted by the manufacturer count toward your true out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by your plan does not count toward your true out-of-pocket costs.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service. Phone numbers are printed on the back cover of this booklet.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 50% discount on covered brand-name drugs. The 50% discount is applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are

also covered by ADAP qualify for prescription cost sharing assistance. **Note:** To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For contact information, please refer to the state-specific agency listing located in Chapter 11.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next *Part D Explanation of Benefits (Part D EOB)* notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are located in Chapter 11 of this booklet) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs (SPAP) that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members.

For contact information for SPAP, please refer to the state-specific agency listing located in Chapter 11 of this booklet.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	**1-877-772-5772** Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	**www.rrb.gov**

SECTION 9 Do you have "group insurance" or other health insurance from another group sponsor?

If you have group insurance from another group sponsor, employer or union, please contact **that group sponsor's benefits administrator** to identify how that coverage will work with these benefits. You may also call **1-800-MEDICARE (1-800-633-4227;** TTY: **1-877-486-2048)** with questions related to your Medicare coverage under this plan.

CHAPTER 3

Using the plan's coverage for your Part D prescription drugs

Using the plan's coverage for your Part D prescription drugs

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Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information on these programs, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** If you qualify for "Extra Help," we will send you a separate insert, called the *"Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"* (also known as the *"Low Income Subsidy Rider"* or the *"LIS Rider"*), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the *"LIS Rider."* Phone numbers for Customer Service are printed on the back cover of this booklet.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs: Chapter 4, "What you pay for your Part D prescription drugs."

In addition to your coverage for Part D drugs through your plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, drugs you are given at a dialysis facility, and certain drugs you receive via medical equipment such as nebulizers.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* Handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.2 Basic rules for your plan's Part D drug coverage

Your plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- You generally must use a network pharmacy to fill your prescription. (See Section 2: "Fill your prescription at a network pharmacy.")
- The drug is a Medicare Part D eligible drug. Medicare Part D eligible drugs are all approved by the FDA and if brand, the drug manufacturer has agreed to provide the Coverage Gap Discount. The drugs covered under your retiree drug coverage are listed in your plan's *Drug List* or your benefit chart located at the front of this booklet.
  - If your plan uses a *Closed Drug List (Closed Formulary)*, you have coverage for most, but not all, Medicare Part D eligible drugs. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. Not all drugs are on the *Closed Formulary*. (The benefit chart located at the front of this booklet will tell you if your plan has a Closed Formulary.)
  - If your plan uses an *Open Drug List (Open Formulary)*, generally you have coverage for all Medicare Part D eligible drugs. (The benefit chart at the front of this booklet will tell you if your plan has an Open Formulary.)
- You may also have coverage for certain additional drugs not covered by Medicare Part D plans. These drugs are referred to as “Extra Covered Drugs” and are covered by your Senior Rx Plus supplemental benefits. If your plan includes coverage for additional drugs, the benefit chart located at the front of this booklet will have a section called “Extra Covered Drugs.” You can find out which specific drugs are covered by checking your *Extra Covered Drug List(s)*.
- We evaluate new drugs as they come onto the market. Once we have completed a full evaluation based upon clinical effectiveness and cost relative to other drug therapies, the drug will be assigned to a drug plan tier or non-formulary designation. If a new Part D-eligible drug is designated as non-formulary following our review, you will have coverage for it only if your plan uses an Open Formulary. A Closed Formulary does not provide coverage for a non-formulary drug. During the period between the time the drug is first available and our review, the drug will not be automatically covered. If your physician feels you should use the new drug, you or your physician may request a coverage exception.
- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Section 3.1 for more information about a medically accepted indication.

SECTION 2 Fill your prescription at a network pharmacy or through your plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at your plan's network pharmacies. See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.

A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means certain Part D eligible prescription drugs and "Extra Covered Drugs," if shown in the benefit chart located at the front of this booklet.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory* or call Customer Service. Phone numbers are printed on the back cover of this booklet.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

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

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves your plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service. Phone numbers are printed on the back cover of this booklet.

- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Customer Service. Phone numbers are printed on the back cover of this booklet.

Section 2.3 Using your plan's mail-order services

Your plan's mail-order service allows you to order **up to a 90-day supply for most drugs. Specialty drugs are only available in a 30-day supply** on most plans. Please check the benefit chart located at the front of this booklet to verify the maximum day supply limits in your plan for mail-order drugs.

To get order forms and information about filling your prescriptions by mail, please call Customer Service. Usually a mail-order pharmacy order will get to you in no more than 14 days. Pharmacy processing time will average about two to five business days; however, you should allow additional time for postal service delivery. It is advisable for first-time users of the mail-order pharmacy to have at least a 30-day supply of medication on hand when a mail-order request is placed. If the prescription order has insufficient information, or if we need to contact the prescribing physician, delivery could take longer.

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by calling Customer Service at the number on your membership card.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Customer Service. Phone numbers are printed on the back cover of this booklet.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the

pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling Customer Service. Phone numbers are printed on the back cover of this booklet.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 21 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by calling Customer Service. Phone numbers are printed on the back cover of this booklet.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. Your plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on your plan's *Drug List*. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. You are not required to use the mail-order service to get a longer term supply of maintenance drugs. If you get a longer term supply of maintenance drugs at a retail network pharmacy, your cost sharing may be different than it is for a longer term supply from the mail-order service. Please check the benefit chart located at the front of this booklet to find out what your costs will be if you get a longer term supply of maintenance drugs from a retail pharmacy. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a longer-term supply of maintenance drugs. You can also call Customer Service for more information. Phone numbers are printed on the back cover of this booklet.
2. For many drugs, you can use your plan's network **mail-order services.** Our plan's mail-order service allows you to order up to a 90-day supply for most drugs. Specialty drugs are typically only available in a 30-day supply. Please check the benefit chart located at the front of this booklet to verify the maximum day supply limits in your plan for mail-order drugs. See Section 2.3 for more information about using your mail-order services.

Section 2.5 When can you use a pharmacy that is not in your plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy.

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- You are unable to obtain a covered drug in a timely manner within our service area because a network pharmacy that provides 24-hour service is not available within a 25-mile driving distance.
- You are filling a prescription for a covered drug and that particular drug (for example, an orphan drug or other specialty pharmaceutical) is not regularly stocked at an accessible network retail or mail-order pharmacy.
- The prescription is for a medical emergency or urgent care.

Additionally, the pharmacy is not located outside the United States or its territories.

In these situations, please check first with Customer Service to see if there is a network pharmacy in the area where you are traveling within the United States. Phone numbers for Customer Service are printed on the back cover of this booklet. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from your plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Chapter 5, Section 2.1 explains how to ask your plan to pay you back.

After all benefits are provided under your retiree drug coverage, in addition to paying the copayments/coinsurances listed on the benefit chart located at the front of this booklet, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

SECTION 3 If you have a Closed Formulary Plan, your drugs need to be on your plan's "*Drug List*"

Section 3.1 The "*Drug List*" tells which Part D drugs are covered

Your plan has a "*List of Covered Drugs (Formulary)."* In this *Evidence of Coverage*, we call it the "*Drug List*" for short.

The drugs on this list are selected by your plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved your plan's *Drug List*.

We will generally cover a drug on your plan's *Drug List* as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- *-- or --* Supported by certain reference books. (These reference books are the *American Hospital Formulary Service Drug Information*, the *DRUGDEX Information System*, and the *USPDI* or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

Your *Drug List* includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.

- Your plan does not require you to pay the difference between the cost of a covered brand drug and the covered generic drug if your doctor feels you should use the brand drug. You will only pay the brand copayment when you fill a covered brand drug at a network pharmacy.

What is *not* on the *Drug List*?

Your plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. For more about this, see Section 7.1 in this chapter.
- In other cases, we have decided not to include a particular drug on our *Drug List*.

Section 3.2 How do "cost sharing tiers" for drugs on the *Drug List* impact my cost?

Every drug on your plan's *Drug List* is in one of your plan's cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug. The types of drugs placed into the cost sharing tiers used by your plan are shown in the benefit chart located at the front of this booklet.

To find out which cost sharing tier your drug is in, please check your plan's *Drug List.*

The amount you pay for drugs in each cost sharing tier is also shown in the benefit chart located at the front of this booklet.

Section 3.3 How can you find out if a specific drug is on your *Drug List*?

You have two ways to find out:

1. Check the most recent *Drug List* we sent you in the mail.

2. Call Customer Service to find out if a particular drug is on your plan's *Drug List* or to ask for a copy of the list. Phone numbers for Customer Service are printed on the back cover of this booklet.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when your plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, your plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. See Chapter 7, Section 5.2 for information about asking for exceptions.

Please note that sometimes a drug may appear more than once in our *Drug List*. This is because different restrictions or cost sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Your plan uses different types of restrictions to help members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand-name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand-name drug and usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version.** However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. Your share of the cost may be greater for the brand-name drug than for the generic drug.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from us before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes the requirement for

getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by your plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before your plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, your plan may require you to try Drug A first. If Drug A does not work for you, your plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy."**

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

Your plan's *Drug List* includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check your *Drug List*. For the most up-to-date information, call Customer Service. Phone numbers are printed on the back cover of this booklet.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. See Chapter 7, Section 5.2 for information about asking for exceptions.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our *formulary* or is on our *formulary* with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered, but the brand-name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by your plan have extra rules to restrict

their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. The drug is covered, but it is in a cost sharing tier that makes your cost sharing more expensive than you think it should be. Your plan puts each covered drug into one cost sharing tier. How much you pay for your prescription depends in part on which cost sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the *Drug List* or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is restricted in some way?

If coverage for your drug is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask your plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, your plan can offer a temporary supply of a drug to you when your drug is not on the *Drug List* or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. **The change to your drug coverage must be one of the following types of changes:**
   - If you are on a Closed Formulary plan, the drug you have been taking is **no longer on your plan's *Drug List*.**
   - Or for all plans, the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).
2. **You must be in one of the situations described below:**
   - **For those members who are new or who were in this plan last year and aren't in a long-term care (LTC) facility:**

     We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the benefit year if you were in the plan last year.** This temporary supply will be for a maximum

of a 30-day supply, or less. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year.** The total supply will be for a maximum of a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days, and reside in a long-term care (LTC) facility and need a supply right away:**
  We will cover one 31-day supply of a particular drug, or less, if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call Customer Service. Phone numbers are printed on the back cover of this booklet.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by your plan or ask us to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by your plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Customer Service are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask us to cover a drug even though it is not on your plan's *Drug List*. Or you can ask us to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost sharing tier you think is too high?

If your drug is in a cost sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Customer Service are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask your plan to make an exception in the cost sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly. Drugs in some of our cost sharing tiers are not eligible for this type of exception. If your plan has a separate specialty tier, specialty drugs are not eligible for a tiering exception.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The *Drug List* can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, your plan might make changes to your *Drug List*. You will receive notice when necessary. For example, your plan might:

- **Add or remove drugs from the *Drug List*.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost sharing tier**.
- **Add or remove a restriction on coverage for a drug**. For more information about restrictions to coverage, see Section 4 in this chapter.
- **Replace a brand-name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to your plan's *Drug List*.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, your plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, your plan will immediately remove the drug from your *Drug List*. We will let you know of this change right away. Your provider will also know about this change and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in your plan:

- If we move your drug into a higher cost sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the *Drug List*, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug**, we must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, we will immediately remove the drug from the *Drug List*. We will let you know of this change right away.
  - Your provider will also know about this change and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by your plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself, unless they are covered under your Senior Rx Plus coverage. If you have coverage for these drugs, they will be listed in the "Extra Covered Drugs" section of the benefit chart at the front of this booklet. In some cases excluded drugs may be covered under your medical plan.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Your plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Your plan cannot cover a drug purchased outside the United States and its territories.
- Your plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Medicare sometimes allows us to cover "off-label uses" of a prescription drug. Coverage is allowed only when the use is supported by certain reference books. These reference books are the *American Hospital Formulary Service Drug Information*, the *DRUGDEX Information System*, and for cancer, the guidelines posted by the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books or noted authority, then your plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans unless your plan covers them as "Extra Covered Drugs." Please see the "Extra Covered Drugs" section of the benefit chart located at the front of this booklet to find out which of the drugs listed below are covered under your group sponsored plan.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs that Medicare does not classify as Part D drugs, including when these drugs are ingredients in a compounded drug
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain, unless used to treat HIV or cancer wasting

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you have coverage for some prescription drugs not normally covered in a Medicare prescription drug plan, shown in the "Extra Covered Drugs" section of the benefit chart located at the front of this booklet, the amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.)

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" will not pay for the drugs not normally covered. Please refer to your plan's *Drug List* or call Customer Service for more information. Phone numbers for Customer Service are printed on the back cover of this booklet. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. For contact information, please refer to the state-specific agency listing located in Chapter 11.

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill your plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 5, Section 2.1 for information about how to ask your plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?

If you are admitted to a hospital for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital,

your Part D plan will cover your drugs as long as the drugs meet all rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are admitted to a skilled nursing facility for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, your Part D plan will cover your drugs as long as the drugs meet all rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. Chapter 8, "Ending your membership in the plan," tells when you can leave your plan and join a different Medicare plan.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care (LTC) facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care (LTC) facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service. Phone numbers are printed on the back cover of this booklet.

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on your *Drug List* or is restricted in some way, we will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 98-day supply, or less, if your prescription is written for fewer days. Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.

If you have been a member of your plan for more than 90 days and need a drug that is not on your *Drug List* or, if your plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less, if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by your plan that might work just as well for you. Or you and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in this plan doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations, and through your Part D plan in other situations. But drugs are never covered by both Part B and your Part D plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or your Part D plan for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in this Part D plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year, your Medigap insurance company should send you a notice that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from another retiree group sponsored plan?

Do you currently have other prescription drug coverage through your (or your spouse's) retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with your plan.

Section 9.6 What if you are in a Medicare-certified Hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or anti-anxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 4, "What you pay for your Part D prescription drugs," gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems, such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Medication Therapy Management (MTM) and other programs to help members manage their medications

We have programs that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members get the most benefit from the drugs they take. One program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. If you qualify, a pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary

has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly Wellness visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit, or anytime you talk with your doctors, pharmacists and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service. Phone numbers are printed on the back cover of this booklet.

CHAPTER 4

What you pay for your Part D prescription drugs

What you pay for your Part D prescription drugs

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Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7. For contact information, please refer to the state-specific agency listing located in Chapter 11.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We will send you the *"Evidence of Coverage Rider for People Who Get 'Extra Help' Paying for Prescription Drugs"* (also known as the *"Low Income Subsidy Rider"* or the *"LIS Rider"*), which tells you about your drug coverage. If you don't have this letter, please call Customer Service and ask for the *"LIS Rider."* Phone numbers for Customer Service are printed on the back cover of this booklet.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B, and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered by your plan. If your plan includes coverage for any Part D excluded drugs, the benefit chart located at the front of this booklet will have a section called "Extra Covered Drugs."

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **Your plan's *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the *"Drug List."*
  - This *Drug List* tells which drugs are covered for you.
  - It also tells which of the "cost sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of your *Drug List*, call Customer Service. Phone numbers are printed on the back cover of this booklet.
- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by your plan.
- **Your plan's *Pharmacy Directory*.** In most situations, you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in your plan's network. It also tells you which pharmacies in our network

can give you a long-term supply of a drug (such as filling a prescription for a three-months' supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost sharing," and there are three ways you may be asked to pay:

- **"Deductible"** (if your plan has one) is the amount you pay for drugs before your plan begins to pay its share.
- **"Copayment"** is a fixed amount you pay each time you fill a prescription.
- **"Coinsurance"** is a percent of the total cost of the drug you pay each time you fill a prescription.

SECTION 2 What you pay for a drug depends on which "drug coverage stage" you are in when you get the drug

Section 2.1 What are the drug coverage stages?

As shown in the table below, there are four "drug coverage stages" that may be used in your plan. The drug coverage stages used in your plan are shown in the benefit chart located at the front of this booklet. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1 *Deductible Stage*	Stage 2 *Initial Coverage Stage*	Stage 3 *Coverage Gap Stage*	Stage 4 *Catastrophic Coverage Stage*
If your plan has a deductible stage, you begin in this stage when you fill your first prescription of the year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid the deductible amount	Your plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until you reach the amount shown on the benefit chart located at the front of this booklet.	If your copay or coinsurance payment does not change until you reach your True Out-of-Pocket amount, the benefit chart located at the front of this booklet will not have a "Gap Coverage" section.	Once you have paid enough for your drugs to move on to this last stage, **your cost for your drugs may be reduced** for the rest of the benefit year. The amount you pay for drugs in the Catastrophic Stage is shown at the benefit

Stage 1 *Deductible Stage*	Stage 2 *Initial Coverage Stage*	Stage 3 *Coverage Gap Stage*	Stage 4 *Catastrophic Coverage Stage*
shown at the benefit chart located at the front of this booklet.		If your copay or coinsurance payment does change once you reach the $3,310 Initial Coverage Limit, the benefit chart located at the front of this booklet will include a "Gap Coverage" section that shows what you must pay during the Coverage Gap Stage. The copay or coinsurance shown in the benefit chart is the amount you pay in this stage after your plan and the Coverage Gap Discount have paid their amounts.	chart located at the front of this booklet.

SECTION 3 We send you reports that explain payments for your drugs and which coverage stage you are in

Section 3.1 We send you a monthly report called the "*Part D Explanation of Benefits*" (the "*Part D EOB*")

Your plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug coverage stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by your plan.

Your plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the "*Part D EOB*") when you have had one or more prescriptions filled through your plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what your Group Part D and Senior Rx Plus coverage paid, what the Coverage Gap Discount paid and what you and others on your behalf paid.
- **Important note about the way amounts paid by your retiree drug coverage may look in your *EOB*:** Your retiree drug coverage is always equal to or greater than basic Part D coverage by itself. However, on a specific drug your plan copayment or coinsurance amount may be greater than it would if you had basic Part D coverage by itself. If the basic Part D coverage would be greater than your retiree drug coverage, the amount shown in the "other payments" column in your *EOB* may be negative. In this case the negative amount is the way Medicare wants us to account for this difference. It is not an error and it does not mean you made an overpayment.
- **Totals for the calendar year.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask us to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of your plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian

Health Service and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a "*Part D EOB*") in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Customer Service. Phone numbers are printed on the back cover of this booklet. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Section 4.1 You stay in the Deductible Stage until you have paid the amount listed in your benefit chart for your drugs

If your plan has a Deductible Stage, this stage is the first coverage stage for your drug coverage. This stage begins when you fill your first prescription in the calendar year. When you are in this coverage stage, **you must pay the full cost of your drugs** until you reach your plan's deductible amount.

- Your **"full cost"** is usually lower than the normal full price of the drug, since your plan has negotiated lower costs for most drugs.
- The **"deductible"** is the amount you must pay for your Part D prescription drugs before your plan begins to pay its share.

If your plan has a deductible, once you have paid the deductible amount for your drugs, you move on to the next drug coverage stage, which is the Initial Coverage Stage. If your plan does not have a deductible, you begin in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, your plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, your plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

Your plan has cost sharing tiers

Every drug on your plan's *Drug List* is in one of its cost sharing tiers. In general, the higher the cost sharing tier number, the higher your cost for the drug.

To find out what copayment or coinsurance you will pay for drugs in each cost sharing tier, please see the benefit chart located at the front of this booklet.

To find out which cost sharing tier your drug is in, please check your plan's *Drug List*.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in your plan's network
- A pharmacy that is not in your plan's network
- Your plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and your plan's *Pharmacy Directory*. You may also contact Customer Service. Phone numbers are printed on the back cover of this booklet.

Section 5.2 When does the Initial Coverage Stage end?

If your plan provides the same coverage until you reach your True Out-of-Pocket amount, your plan's Initial Coverage stage continues until you reach your True Out-of-Pocket limit. The benefit chart located at the front of this booklet will not show an Initial Coverage Limit amount. It will only show the True Out-of-Pocket amount.

If your plan provides different coverage in the Coverage Gap stage after the Initial Coverage limit is reached, the benefit chart located at the front of this booklet will show the Initial Coverage Limit amount and include a Coverage Gap section.

If your plan includes an Initial Coverage Limit, your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the calendar year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - Any deductible amounts you paid when you were in the Deductible Stage, if you have one.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What your plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2016, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare prescription drug plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be

times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost sharing rate") and multiply it by the number of days of the drug you receive.
  - Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan the refill date for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

SECTION 6 Your cost for covered Part D drugs may change once the amount you and your plan pay reaches $3,310

Section 6.1 You can look at the benefit chart located at the front of this booklet to find out if your copay or coinsurance changes once you and the plan have paid $3,310 for covered Part D drugs

If your copay or coinsurance amount does not change until you reach your True Out-of-Pocket amount, the benefit chart located at the front of this booklet will not have a "Gap Coverage" section.

If your copay or coinsurance amount does change once you reach the $3,310 Initial Coverage Limit, the benefit chart located at the front of this booklet will include a "Gap Coverage" section that shows what you must pay during the Gap Coverage Stage.

If you are not receiving help to pay your share of drug costs through the Low Income Subsidy or PACE programs, you qualify for a discount on the cost you pay for most covered brand drugs

through the Medicare Coverage Gap Discount Program. For prescriptions filled in 2016, once the cost paid by you and this plan reaches $3,310, the cost share you pay will reflect all benefits provided by your retiree drug coverage and the Coverage Gap Discount program. The Coverage Gap Discount program applies until the cost paid by you (or those paying on your behalf as defined in Section 6.2) reaches $4,850.

Drug Manufacturers have agreed to provide this discount on brand drugs which Medicare considers Part D qualified drugs. Your plan may cover some brand drugs beyond those covered by Medicare. The discount will not apply to benefits described in the "Extra Covered Drugs" section of the benefit chart located at the front of this booklet. The "Extra Covered Drugs" benefit, if included, is provided by your Senior Rx Plus coverage. Once your True Out-of-Pocket costs reach the amount shown on the benefit chart located at the front of this booklet, you will move onto the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments are included in your out-of-pocket costs:

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3 of this booklet):

- The amount you pay for drugs when you are in any of the following drug coverage stages:
  - The Deductible Stage (if your plan has this stage).
  - The Initial Coverage Stage.
  - The Coverage Gap Stage (if your plan has this stage).
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined your plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs (ADAP), by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Payments made by the Medicare Coverage Gap Discount Program are also included.

Moving on to the Catastrophic Coverage Stage:

When the amount you (or those paying on your behalf) have paid for covered drugs reaches the True Out-of-Pocket (TrOOP) amount listed in the benefit chart located at the front of this booklet, you will move to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you, or others on your behalf, pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by your plan.
- Drugs you get at an out-of-network pharmacy that do not meet the requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under the "Extra Covered Drugs" benefit, when these are included in your Senior Rx Plus coverage.
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.
- Payments for your drugs that are made by your Part D or Senior Rx Plus coverage.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and the Veterans Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, workers' compensation).

Reminder: If any other organization pays part or all of your out-of-pocket costs for drugs, you are required to tell your plan. Call Customer Service to let us know. Phone numbers are printed on the back cover of this booklet.

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Part D Explanation of Benefits (Part D EOB)* report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report).
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, your plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the benefit year

You qualify for the Catastrophic Coverage Stage when you have reached your out-of-pocket limit for the year. Once you are in the Catastrophic Coverage Stage, you will stay in this coverage stage until the end of the year.

During this stage, the cost you pay for your drugs may be reduced. You can find your cost sharing amounts in the Catastrophic Coverage section of the benefit chart located at the front of this booklet.

SECTION 8 Additional benefits information

Section 8.1 Your plan offers additional benefits

Your Senior Rx Plus coverage may include the "Extra Covered Drugs" benefit. Payments made for these drugs will not count toward your Initial Coverage Limit or your True Out-of-Pocket limit. If your plan includes coverage for additional drugs, the benefit chart located at the front of this booklet will have a section called "Extra Covered Drugs." You can find out which specific drugs are covered by checking your *Extra Covered Drug List(s)*.

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1 Your plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Your plan provides coverage for a number of Part D vaccines. There are two parts to your coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).

- Some vaccines are considered Part D drugs. You can find these vaccines listed in your plan's *List of Covered Drugs* (*Formulary*).
- Other vaccines are considered medical benefits. They are covered under Original Medicare.

2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask your plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. If you have a Deductible or Coverage Gap Stage, you are responsible for most of the costs associated with vaccines (including their administration) during these coverage stages of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine and of the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask your plan to pay its share of the cost by using the procedures that are described in Chapter 5 of this booklet, "Asking us to pay our share of the costs for covered drugs."
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask us to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.

- You will be reimbursed the amount charged by the doctor less the amount for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Please note that Part B covers the vaccine and administration for influenza, pneumonia and Hepatitis B injections.

When billing us for a vaccine, please include a bill from the provider with the date of service, the National Drug Code (NDC), the vaccine name and the amount charged. Send the bill to:

Express Scripts, Inc.
ATTN: MED D ACCTS
P.O. BOX 14718
Lexington, KY 40512-4718

You may want to call us before you go to your doctor so we can help you understand the costs associated with vaccines (including administration) available under this plan. For more information, please contact Customer Service. Phone numbers are listed on the back cover of this booklet.

Section 9.2 You may want to call Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. Phone numbers for Customer Service are printed on the back cover of this booklet.

- We can tell you how your vaccination is covered by your plan and explain your share of the cost – including whether the vaccination is covered by Medicare Part D or Part B.
- We can tell you how to keep your own cost down by using providers and pharmacies in your network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 10 Do you have to pay the Part D "late enrollment penalty?"

Section 10.1 What is the Part D "late enrollment penalty?"

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards, since it is expected to pay, on average, at least as much as Medicare's

standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

Your late enrollment penalty is considered to be part of your plan premium.

The late enrollment penalty is added to the monthly premium charged to your (or your spouse's) group for your coverage. If you think you may have a late enrollment penalty, you should contact your (or your spouse's) group to see what amount you will have to pay. However, if you are billed directly by your plan for your monthly premium, the late enrollment penalty will be included in the bill you receive from us.

Section 10.2 How much is the Part D "late enrollment penalty?"

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2015, this average premium amount was $33.13. This amount may change for 2016.
- To calculate your monthly penalty, you multiply the penalty percentage and round it to the nearest 10 cents. In the example here, it would be 14% times $33.13, which equals $4.64. This rounds to $4.70. This amount would be added **to the monthly premium for someone with a late enrollment penalty.**

There are three important things to note about this monthly late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are <u>under</u> 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you are eligible for Medicare and are under 65, any late enrollment penalty you are paying will be eliminated when you attain age 65. After age 65, your late enrollment penalty is based only on the months you do not have coverage after your Age 65 Initial Enrollment Period.

Section 10.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a group, former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - **Please note:** If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2016* Handbook or call **Medicare** at **1-800-MEDICARE (1-800-633-4227)**. TTY users, call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 10.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Service to find out more about how to do this. Phone numbers are printed on the back cover of this booklet.

Important: Do not stop paying your late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 11 Do you have to pay an extra Part D amount because of your income?

Section 11.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. This is known as the Income Related Monthly Adjustment Amount, also known as IRMAA. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

Part D-IRMAA (Income Related Monthly Adjustment Amount) is assessed to all Medicare beneficiaries with Part D coverage whose incomes exceed the federal government established threshold amounts. CMS has emphasized that failure by a Medicare beneficiary to pay the Part D-IRMAA will result in involuntary disenrollment from their Part D plan and, thus, the loss of retiree drug and/or health coverage through their group.

Please carefully review all communications you receive from CMS. As a Part D plan sponsor, we are not billing or collecting the Part D-IRMAA; however, as a plan sponsor we must be prepared to effectuate accurate disenrollments in situations where individuals fail to pay the income-related adjustment.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 11.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in *2014* was:	If you were married but filed a separate tax return and your income in *2014* was:	If you filed a joint tax return and your income in *2014* was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium):
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	Your plan premium

If you filed an individual tax return and your income in *2014* was:	If you were married but filed a separate tax return and your income in *2014* was:	If you filed a joint tax return and your income in *2014* was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium):
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$12.70 + Your plan premium
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$32.80 + Your plan premium
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$52.80 + Your plan premium
Greater than $214,000	Greater than $129,000	Greater than $428,000	$72.90 + Your plan premium

Section 11.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at **1-800-772-1213** (TTY: **1-800-325-0778**).

Section 11.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you **will** be disenrolled from the plan and lose prescription drug coverage.

CHAPTER 5

Asking us to pay our share of the costs for covered drugs

Asking us to pay our share of the costs for covered drugs

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SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of your plan. In either case, you can ask your plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask your plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

1. **When you use an out-of-network pharmacy to get a prescription filled**
   If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Section 2.5 to learn more.)

   Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. **When you pay the full cost for a prescription because you don't have your plan membership card with you**
   If you do not have your plan membership card with you, you can ask the pharmacy to call your plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

   Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

3. **When you pay the full cost for a prescription in other situations**
   You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

   - For example, the drug may not be on your plan's *List of Covered Drugs* (*Formulary*), or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
   - Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. **If you are retroactively enrolled in our plan**
   Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

   If you were retroactively enrolled in our plan and you paid out of pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the cost. You will need to submit paperwork for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Customer Service are printed on the back cover of this booklet.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)," has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.

Please contact Customer Service and ask for the form. Phone numbers are printed on the back cover of this booklet.

Mail your request for payment together with any receipts to us at this address:

Express Scripts, Inc.
ATTN: MED D ACCTS
P.O. BOX 14718
Lexington, KY 40512-4718

Contact Customer Service if you have any questions. Phone numbers are printed on the back cover of this booklet. If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of all but your share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)." The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. **When you buy the drug for a price that is lower than our price**
   If your plan includes stages in which you are responsible for 100% of the drug costs, such as a deductible stage, sometimes you can buy your drug **at a network pharmacy** for a price that is lower than our price.
   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
   - Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on your *Drug List*.
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
   - **Please note:** If you are in a Part D plan stage in which you are responsible for 100% of the drug costs, your Part D plan will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.
2. **When you get a drug through a patient assistance program offered by a drug manufacturer**
   Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside your Part D plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
   - **Please note:** Because you are getting your drug through the patient assistance program and not through your Part D plan's benefits, your Part D plan will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 6

Your rights and responsibilities

Your rights and responsibilities

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SECTION 1 Your plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats)

To get information from us in a way that works for you, please call Customer Service. Phone numbers are printed on the back cover of this booklet.

Your plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about your plan's benefits that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from your plan because of problems related to language or a disability, please call **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users, call **1-877-486-2048**.

Section 1.2 We must treat you with fairness and respect at all times

Your plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY: **1-800-537-7697**) or your local Office for Civil Rights. For contact information, please refer to the state-specific agency listing located in Chapter 11.

If you have a disability and need help with access to care, please call Customer Service. Phone numbers are printed on the back cover of this booklet. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered drugs

As a member of this plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in your plan, as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you our written notice later in this chapter, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of your plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at your plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service. Phone numbers are printed on the back cover of this booklet.

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices

- Breast reconstruction surgery benefits

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your non-public personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital.

Examples of ways we use your information for payment, treatment and health and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share your *Explanation of Benefits (EOB)* with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit **https://www.anthem.com/ca/health-insurance/about-us/privacy** for more information.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide. You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities;
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents);

- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety;
- Special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

If you submit an online enrollment application for a Medicare Advantage, Medicare Advantage Part D or Part D Prescription Drug Plan, or if an agent/broker submits it on your behalf, we record the Internet Protocol (IP) address the application is submitted from. We use this information in our efforts to prevent and detect fraud, waste and abuse in the Medicare program.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger. Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment

or operations reasons. If you or your provider submits a claim to us, we do not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, we do not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law, in addition to HIPAA.

Contacting You

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment or billing.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective Date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date of this Notice is January 1, 2015.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or coinsurance. Contact Customer Service for more information.

Anthem Blue Cross

Section 1.5 We must give you information about your plan, its network of pharmacies and your covered drugs

As a member of your plan, you have the right to get several kinds of information from us. As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.

If you want any of the following kinds of information, please call Customer Service. Phone numbers are printed on the back cover of this booklet:

- **Information about your plan.** This includes, for example, information about your plan's financial condition. It also includes information about the number of appeals made by members and your plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in your plan's network, see the *Pharmacy Directory.*

- For more detailed information about our pharmacies, you can call Customer Service. Phone numbers are printed on the back cover of this booklet.

- **Information about your coverage and the rules you must follow when using your coverage.**
  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet, plus your plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service. Phone numbers are printed on the back cover of this booklet.
- **Information about why something is not covered and what you can do about it.**
  - If a Part D drug is not covered for you, or, if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation, even if you received the drug from an out-of-network pharmacy.
  - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. Chapter 7 also tells how to make a complaint about quality of care, waiting times and other concerns.
  - If you want to ask your plan to pay its share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state-specific agency (such as the State Department of Health). For contact information, please refer to the state-specific agency listing located in Chapter 11.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask your plan to make a coverage decision for you, make an appeal to us to change a coverage decision or make a complaint. Whatever you do – ask for a coverage decision, make an appeal or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against your plan in the past. To get this information, please call Customer Service. Phone numbers are printed on the back cover of this booklet.

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY: **1-800-537-7697**), or call your local Office for Civil Rights. For contact information, please refer to the state-specific agency listing located in Chapter 11.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service.** Phone numbers are printed on the back cover of this booklet.
- You can **call the State Health Insurance Assistance Program**. For details about this organization, go to Chapter 2, Section 3. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- Or, you can **call Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service**. Phone numbers are printed on the back cover of this booklet.
- You can **call the State Health Insurance Assistance Program**. For details about this organization, go to Chapter 2, Section 3. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- You can **contact Medicare**.
  - You can visit the Medicare website to read or download the publication *"Your Medicare Rights & Protections."* (The publication is available at: **www.medicare.gov/Pubs/pdf/11534.pdf**)
  - Or, you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 2 You have some responsibilities as a member of your plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of your plan are listed below. If you have any questions, please call Customer Service. Phone numbers are printed on the back cover of this booklet. We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know. Phone numbers are printed on the back cover of this booklet.
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from your plan. This is called "**coordination of benefits,**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and pharmacist that you are enrolled in this plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums, if any, to your (or your spouse's) group (or, if you are billed directly, you must send your payment to the address listed on your billing statement), to continue being a member of your plan.
  - For most of your drugs covered by your plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). You can find this information listed on the benefit chart located at the front of this booklet.

- If you get any drugs that are not covered by your plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of your plan.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of your plan.

- **Tell us if you move.** If you're going to move, it's important to tell us right away. Call Customer Service. Phone numbers are printed on the back cover of this booklet. Please remember to also notify your former employer or union (group sponsor) of your group plan so they will have your most up-to-date contact information on file. We need to keep your membership record up to date and know how to contact you.
  - **If you move *outside* of your plan service area, you cannot remain a member of your plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you're moving outside of our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* your service area, we still need to know,** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving your plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first. Please call Customer Service. Phone numbers are printed on the back cover of this booklet. We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of your plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with your plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. For contact information, please refer to the state-specific agency listing located in Chapter 11.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- You can visit the Medicare website (**www.medicare.gov**).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, START HERE.

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."

No. My problem is not about benefits or coverage.

Skip ahead to Section 7 at the end of this chapter: "How to make a complaint about quality of care, waiting times, Customer Service or other concerns."

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain

circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to your plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call Customer Service**. Phone numbers are printed on the back cover of this booklet.
- To **get free help from an independent organization** that is not connected with your plan, contact your State Health Insurance Assistance Program. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Service. Phone numbers are printed on the back cover of this booklet. Ask for the "Appointment of Representative" form. The form is also available on Medicare's website at **www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.** The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give your plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (A guide to "the basics" of coverage decisions and appeals)? If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of your plan include coverage for many prescription drugs. Please refer to your plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 3, "Using your plan's coverage for your Part D prescription drugs," and Chapter 4, "What you pay for your Part D prescription drugs."

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on your plan's *List of Covered Drugs (Formulary)*.
  - Asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get).
  - Asking to pay a lower cost sharing amount for a covered non-preferred drug.
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on your plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)

- ***Please note:*** If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that isn't on our *Drug List* or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 5.2** of this chapter.
Do you want us to cover a drug on our *Drug List*, and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to **Section 5.4** of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 5.4** of this chapter.
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask your plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on your plan's *List of Covered Drugs (Formulary)*.** (We call it the *"Drug List"* for short.)

> **Legal Terms**
>
> Asking for coverage of a drug that is not on your *Drug List* is sometimes called asking for a **"formulary exception."**

   - If we agree to make an exception and cover a drug that is not on your *Drug List*, you will need to pay the cost sharing amount that applies to all of our drugs OR drugs for the non-preferred brand tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on your plan's coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on your plan's *List of Covered Drugs (Formulary)* (for more information, go to Chapter 3).

> **Legal Terms**
>
> Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:
     - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
   - If your plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost sharing tier.** Every drug on your plan's *Drug List* is in one of the cost sharing tiers. The cost sharing tiers used in your plan are shown in the benefit chart located at the front of this booklet. In general, the lower the cost sharing tier number, the less you will pay as your share of the cost of the drug.

> **Legal Terms**
>
> Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

   - If your drug is in the non-preferred brand tier, you can ask us to cover it at the cost sharing amount that applies to drugs in the preferred brand tier. This would lower your share of the cost for the drug.

- You cannot ask us to change the cost sharing tier for any drug in the Specialty Drug tier.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, your *Drug List* includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Your plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the benefit year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask your plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing or faxing your plan to make your request. You, your representative or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the topic, "How to contact us when you are asking for a coverage decision about your Part D prescription drugs." Or if you are asking us to pay you back for a drug, go to the section called, "Where to send a request that asks us to pay for our share of the cost for a drug you have received."
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5.4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 5 of this booklet: "Asking us to pay our share of the costs for covered drugs." Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send

us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to your plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form.

If your health requires it, ask us to give you a "fast coverage decision"

Legal Terms

A "fast coverage decision" is called an **"expedited coverage determination."**

- When we give you our decision, we will use the "standard" deadlines, unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for a ***drug you have not yet received***. You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.
  - You can get a fast coverage decision ***only*** if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is

different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

Step 2: Your plan considers your request and we give you our answer.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we'll give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we'll talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we'll send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we're using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about payment for a drug you have already purchased

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later

in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by your plan)

Legal Terms

An appeal to your plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact your plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax or mail, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the topic "How to contact us when you are asking for an appeal about your Part D prescription drugs."
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us** at the phone number shown in Chapter 2, Section 1 under the topic called, "How to contact our plan when you are making an appeal about your Part D prescription drugs."
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.

- If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms
A "fast appeal" is also called an **"expedited redetermination."**

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within seven calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal.
  - If we don't give you a decision within seven calendar days, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than seven calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with your plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with your plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within seven calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you **within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal, and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4 and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal:	**A judge who works for the federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal:	The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal:	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, Customer Service, or other concerns

If your problem is about decisions related to benefits, coverage or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint."

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Service has treated you? • Do you feel you are being encouraged to leave your plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Service or other staff at your plan? ◦ Examples include waiting too long on the phone or when getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4 - 6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

Complaint	Example
	• When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms
• What this section calls a **"complaint"** is also called a **"grievance."** • Another term for **"making a complaint"** is **"filing a grievance."** • Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Phone numbers are printed on the back cover of this booklet.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
  - You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the court or in accordance with state law to act for you. If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service. Phone numbers are printed on the back cover of this booklet.
  - A grievance must be filed either verbally or in writing within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

  - A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.
- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint**. If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to your plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address and phone number of the Quality Improvement Organization for your state, please refer to the state-specific agency listing located in Chapter 11. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to your plan and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about your plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel your plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

CHAPTER 8

Ending your membership in the plan

8. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in our plan. Section 2 tells you *when* you can end your membership in our plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan anytime during the year. **Ending your group sponsored Medicare Part D plan may impact your eligibility for other coverage sponsored by your group. You may not be able to re-enroll in your plan in the future. If you end your group Medicare Part D coverage, your Senior Rx Plus supplemental coverage will end on the same date. Before ending your group sponsored Medicare Part D coverage, please contact your (or your spouse's) group.**

Note: If you disenroll from a Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 4, Section 10 for more information about the late enrollment penalty.

Section 2.1 You can end your membership during the Annual Enrollment Period for Individual (non-group) plans

You can end your membership during the Annual Enrollment Period for Individual (non-group) plans (also known as the "Annual Coordinated Election Period"). This is the time when you

should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period for Individual (non-group) plans?** This happens from October 15 through December 7.
- **What type of plan can you switch to during the Annual Enrollment Period for Individual (non-group) plans?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - An Individual (non-group) Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
    - *Or,* an Individual (non-group) Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (hospital) and Part B (medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
- **Ending your group sponsored Medicare Part D plan may impact your eligibility for other coverage sponsored by your group, or mean that you will not be able to re-enroll in your plan in the future. Before ending your group sponsored Medicare Part D coverage, please contact your (or your spouse's) group.**
- **If you end your group Medicare Part D coverage, your Senior Rx Plus supplemental coverage will end on the same date.**
- **Note:** If you disenroll from a Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 4, Section 10 for more information about the late enrollment penalty.
- **When will your group sponsored plan membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

Group sponsored plans may allow changes to their retirees' enrollment during the group's open enrollment period. This may be any time of the year and does not have to coincide with the individual open enrollment period.

Please check with your (or your spouse's) group for additional enrollment and disenrollment options, and the impact of any changes to your group sponsored retiree benefits.

In certain situations, members of this group sponsored Part D plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples; for the full list, you can contact us, call Medicare or visit the Medicare website **(www.medicare.gov)**:
  - If you have permanently moved outside of the United States.
  - If you have Medicaid.
  - If you are eligible for "Extra Help" paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service. Phone numbers are printed on the back cover of this booklet.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users, call **1-877-486-2048**. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - An Individual (non-group) Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - – *or* – An Individual (non-group) Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (hospital) and Part B (medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
- **Ending your group sponsored Medicare Part D plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in your plan in the future. Before ending your group sponsored Medicare Part D coverage, please contact your (or your spouse's) group.**
- **If you end your group Medicare Part D coverage, your Senior Rx Plus supplemental coverage will end on the same date.**

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 4, Section 10 for more information about the late enrollment penalty.

- **When will your group Part D plan membership end?** Your membership will end on the first of the month after we receive your request to change plans or the date you request we terminate coverage on this plan, whichever is later.

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- Contact your (or your spouse's) group's benefits administrator to get information on options available to you.
- You can **call Customer Service**. Phone numbers are printed on the back cover of this booklet.
- You can find the information in the ***Medicare & You 2016*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (**www.medicare.gov**). Or you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in your group sponsored Part D plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, there are two situations in which you will need to end your membership in a different way:

- If you want to switch from your group sponsored Part D plan to Original Medicare *without* a Medicare prescription drug plan, you must contact Customer Service (phone numbers are printed on the back cover of this booklet) and ask to be disenrolled from your plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep

this plan for your drug coverage. If you do not want to keep this plan, you can choose to enroll in another Medicare prescription drug plan or ask to be disenrolled from this plan.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this. Phone numbers are printed on the back cover of this booklet.
- *--or--*You can contact Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 4, Section 10 for more information about the late enrollment penalty.

The table below explains how you should end your membership in your plan.

If you would like to switch from your plan to:	**This is what you should do:**
• An Individual (non-group) Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from your group sponsored plan when your Individual plan's coverage begins.
• An Individual (non-group) Medicare health plan.	• Enroll in the Medicare health plan. With most Medicare health plans, you will automatically be disenrolled from your group sponsored plan when your Individual plan's coverage begins. If you want to leave your plan, you must *either* enroll in another Medicare prescription drug plan *or* contact Customer Service. In order to be disenrolled, you must send us a written request. If you need more information on how to do this, call Customer Service. Phone numbers are printed on the back cover of this booklet. You can also contact Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week (TTY users should call **1-877-486-2048**).

If you would like to switch from your plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan. **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 4, Section 10 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this. Phone numbers are printed on the back cover of this booklet. • You can also contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our Part D plan

If you leave your group sponsored Part D plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through this plan.

- **You should continue to use network pharmacies to get your prescriptions filled until your membership in your plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.

SECTION 5 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We must end your membership in your plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).

- If you move outside the United States.
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in your plan's area. Phone numbers for Customer Service are printed on the back cover of this booklet.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in your plan and that information affects your eligibility for your plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of your plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from your plan and you will lose prescription drug coverage.
- If your group notifies us that they are canceling the group contract for this plan.
- If the premiums paid by your group for this plan are not paid in a timely manner.
- If you pay your plan premium directly to us, and you do not pay your plan premiums for 90 days.
  - We must notify you in writing that you have 90 days to pay your plan premium before we end your membership.
- If your group informs this plan of your loss of eligibility for their group coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information. Phone numbers are printed on the back cover of this booklet.

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave your plan because of a health-related reason, you should call **Medicare** at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

CHAPTER 9

Legal notices

Legal notices

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2 **Notice about non-discrimination** 124

3 **Notice about Medicare Secondary Payer subrogation rights** 124

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SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage*, and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities, even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about non-discrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age or national origin. All organizations that provide Medicare prescription drug plans, like your plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, your plan, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR, and the rules established in this section supersede any state laws.

SECTION 4 Notice about subrogation and reimbursement

Subrogation and reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf from, or take any legal action against, any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. The following apply:

- The amount of our recovery will be calculated pursuant to 42 CFR 411.37, and pursuant to 42 CFR 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.
- Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be

affected, reduced or eliminated by the "made whole" doctrine or any other equitable doctrine.

- You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved, and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate with us, do whatever is necessary to enable us to exercise our rights and do nothing to prejudice our rights.
- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your recovery, whichever is less, from any future benefit under your plan.

SECTION 5 Additional legal notices

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Assignment

The benefits provided under this *Evidence of Coverage* are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

Notice of claim

You have 36 months from the date the prescription was filled to file a paper claim. This applies to claims you submit, and not to pharmacy or provider filed claims.

You may submit such claims to:

Blue Cross MedicareRx (PDP) with Senior Rx Plus
P.O. Box 110
Fond du Lac, WI 54936-0110

Entire contract

This *Evidence of Coverage* and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

Waiver by agents

No agent or other person, except an executive officer of your plan, has authority to waive any conditions or restrictions of this *Evidence of Coverage* or the benefit chart located at the front of this booklet.

No change in this *Evidence of Coverage* shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

Refusal to accept treatment

You may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by your primary care physician. Although such refusal is your right, in some situations it may be regarded as a barrier to the continuance of the provider/patient relationship or to the rendering of the appropriate standard of care.

When a member refuses a recommended, necessary treatment or procedure and the primary care physician believes that no professionally acceptable alternative exists, the member will be advised of this belief.

In the event you discharge yourself from a facility against medical advice, your plan will pay for covered services rendered up to the day of self-discharge. Fees pertaining to that admission will be paid on a per diem basis or appropriate Diagnostic Related Grouping (DRG), whichever is applicable.

Limitation of actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than three years after the service upon which the legal action is based was provided.

Circumstances beyond plan control

If there is an epidemic, catastrophe, general emergency or other circumstance beyond the company's control, neither your plan nor any provider shall have any liability or obligation except the following, as a result of reasonable delay in providing services:

- Because of the occurrence, you may have to obtain covered services from an out-of-network provider instead of an in-network provider. Your plan will reimburse you up to the amount that would have been covered under this *Evidence of Coverage*.
- Your plan may require written statements from you and the medical personnel who attended you confirming your illness or injury and the necessity for the treatment you received.

Plan's sole discretion

Your plan may, at its sole discretion, cover services and supplies not specifically covered by the *Evidence of Coverage*.

This applies if your plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans.
- Information on the procedures your plan uses to control utilization of services and expenditures.
- Information on the financial condition of the company.
- General coverage and comparative plan information.

To obtain this information, call Customer Service. Phone numbers are printed on the back cover of this booklet. Your plan will send this information to you within 30 days of your request.

Information about advance directives

(Information about using a legal form such as a "living will" or "power of attorney" to give directions in advance about your health care in case you become unable to make your own health care decisions).

You have the right to make your own health care decisions. *But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?*

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would *want* and *not want* if you were not able to make decisions for yourself.
- You might want to do both – to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an "advance directive," because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called a "living will" and a "power of attorney for health care" are examples of advance directives.

It's your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance?

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 11 of this booklet tells how to contact your SHIP. (SHIPs have different names depending on which state you are in.)

Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't.

You may want to give copies to close friends or family members as well. If you know ahead of time that you are going to be hospitalized, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, you may file a complaint with your state's Department of Health.

Continuity and coordination of care

Your plan has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, your plan helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D drug benefit when you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have paid your True Out-of-Pocket costs (TrOOP) for covered drugs during the covered year. You can find this amount listed on the benefit chart located at the front of this booklet.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily cost sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost Sharing Tier – Every drug on the list of covered drugs is in one of the cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

Coverage Decision/Determination – A decision about whether a drug prescribed for you is covered by your plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription is not covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by your plan.

Creditable Prescription Drug Coverage – Non-Medicare prescription drug coverage (for example, from a group, employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Customer Service – A department within your plan responsible for answering your questions about your membership, benefits, grievances and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily Cost Sharing Rate – A "daily cost sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30 and a one-month's supply in your plan is 30 days, then your "daily cost sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for prescriptions before your plan begins to pay.

DESI – Drug Efficacy Study Implementation (DESI) review. Drugs entering the market between 1938 and 1962 that were approved for safety but not effectiveness are referred to as "DESI drugs."

Disenroll or **Disenrollment** – The process of ending your membership in your plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispense as Written (DAW) - Specified on a member's prescription by the prescriber when the brand formulation of the medication is preferred over its generic equivalent. This may be due to the prescriber finding medical justification or necessity to have the member take the brand-name drug instead of the generic drug.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require

immediate medical attention to prevent loss of life, loss of a limb or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse.

***Evidence of Coverage* (*EOC*) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders or other optional coverage selected, which explains your coverage, what we must do, your rights and what you have to do as a member of this plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's *formulary* (a formulary exception), or get a non-preferred drug at a lower cost sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or your plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Covered Drugs – This is used to describe coverage of drugs that are excluded by law from coverage by Medicare Part D, but that are included in some group sponsored retiree drug plans. If your plan covers drugs under the "Extra Covered Drugs" benefit, these will be listed in the benefit chart located at the front of this booklet.

"Extra Help" – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles and coinsurance.

Formulary – A list of covered drugs provided by your plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Income-Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage after you have met your deductible (if you have one) and before your total drug costs have reached your initial coverage limit, including amounts you have paid and what we have paid on your behalf. To find out if your plan includes an initial coverage limit, refer to the benefit chart located at the front of this booklet.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help," you do not pay a late enrollment penalty.

List of Covered Drugs (Formulary* or *"Drug List") – A list of prescription drugs covered by your plan. The drugs on this list are selected by your plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Lifestyle Drugs – Drug that is taken to improve quality of life, as opposed to a drug taken to cure or manage an illness. Lifestyle drugs include drugs to treat erectile dysfunction or vaginal dryness. Not all plans cover these drugs. Please check the benefit chart in the front of this booklet to see if your plan includes this coverage.

Low Income Subsidy (LIS) – See **"Extra Help."**

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through your plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer

Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with end-stage renal disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/ Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of this Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in this plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Multi-Source Drug – A prescription drug that is manufactured and sold by more than one pharmaceutical company. Multi-source drugs include both brand and generic drug options.

Network Pharmacy – A network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with us. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-Formulary Drugs – Drugs that are not included in the list of preferred medications that a committee of pharmacists and doctors have deemed to be the safest, most effective and most economical. Non-formulary drugs may not be included in your plan's *Drug List* (*Formulary*); therefore, they would not be covered under your plan, unless you request and receive approval for coverage from us. You can find if non-formulary drugs are covered on your drug plan by referencing the benefit chart located at the front of this booklet.

Non-Preferred Brand Drug – While these drugs meet your Part D plan's safety requirements, a committee of independent practicing doctors and pharmacists which recommends drugs for our *Drug List* did not determine that these drugs provided the same overall value that preferred

brand drugs can offer. If your plan covers both preferred and non-preferred brand drugs, the non-preferred brand drugs usually cost you more. If your plan does not cover non-preferred brand drugs, and your physician feels that you should take the non-preferred brand drug, you may request an exception. Please see Chapter 3, Section 5.2 for how to request an exception.

Non-Preferred Generic Drug – These are generic drugs that cost more than preferred generic drugs. If your plan includes separate preferred and non-preferred generic drug tiers, the non-preferred generic drugs usually cost you more.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with this plan to coordinate or provide covered drugs to members of our plan. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by us unless certain conditions apply.

Out-of-Pocket Costs – See the definition for "**cost sharing**" above. A member's cost sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service. Phone numbers are printed on the back cover of this booklet.

Part C – See "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your *Formulary* for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing levels for certain Part D covered drugs at preferred retail pharmacies in our network.

Preferred Retail Pharmacy – A network pharmacy that offers covered drugs to members of this plan that may have lower cost sharing levels than at other network pharmacies.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preferred Brand Drug – These are brand drugs that have been identified as excellent values both clinically and financially. Before a drug can be designated as a preferred brand drug, a committee of independent practicing doctors and pharmacists evaluates the drug to be sure it meets standards for safety, effectiveness and cost. For most plans, selecting a preferred brand or generic drug will save you money.

Preferred Generic Drug – These are generic drugs that have been identified as excellent values both clinically and financially. If your plan includes separate preferred generic and non-preferred generic drug tiers, then your cost will usually be lower when you choose a preferred generic drug.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our *Formulary*. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the *Formulary*.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state. For contact information, please refer to the state-specific agency listing located in Chapter 11.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Select Generics – A specific list of generic drugs that have been on the market long enough to have a proven track record for effectiveness and value. A complete list of these drugs will be sent along with your *Drug List* (*Formulary*) that accompanies this *Evidence of Coverage*. Some plans have reduced copayments for Select Generics. If your plan includes a reduced copayment, you can find this information listed on the benefit chart located at the front of this booklet.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. Your plan may disenroll you if you permanently move out of your plan's service area.

Single-Source Drug – A prescription brand drug that is manufactured and sold only by the pharmaceutical company that originally researched and developed the drug. Single-source drugs are always brand drugs.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

Specialty Drugs – The Centers for Medicare & Medicaid Services (CMS) defines specialty drugs as any drug that costs $600 or more per unit.

Standard Network Pharmacy – A standard network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "standard network pharmacies" because they contract with us.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

CHAPTER 11

State Organization contact information

11. State organization contact information

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The following state agency information was updated on August 7, 2015. For more recent information or other questions please contact us at Anthem Blue Cross at 1-866-470-6265 or, for TTY users, 711, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays, or visit www.anthem.com/ca.

SECTION 1 State Health Insurance Assistance Program (SHIP)

Alabama

Alabama's State Health Insurance Assistance Program

201 Monroe Street Suite 350
P.O. Box 301851
Montgomery, AL 36104
1-800-243-5463 TTY/TTD: 711
www.alabamaageline.gov

Alaska

Alaska State Health Insurance Assistance Program (SHIP)

400 Gambell Street, Suite 303
Anchorage, AK 99501
1-800-478-6065 TTY/TTD: 1-907-269-3691
http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx

Arizona

Arizona State Health Insurance Assistance Program

1789 W. Jefferson St., #950a
Phoenix, AZ 85007
1-800-432-4040 TTY/TTD: 711
https://www.azdes.gov/daas/ship/

Arkansas

Senior Health Insurance Information Program (SHIIP)

1200 W 3rd Street
Little Rock, AR 72201-1904
1-800-224-6330 TTY/TTD: 711
http://www.insurance.arkansas.gov/shiip.htm

California

California Health Insurance Counseling & Advocacy Program (HICAP)

1300 National Drive
Suite 200
Sacramento, CA 95834-1992
1-800-434-0222 TTY/TTD: 1-800-735-2929
www.aging.ca.gov/HICAP

Colorado

Senior Health Insurance Assistance Program (SHIP)

1560 Broadway
Suite 850
Denver, CO 80202
1-888-696-7213 TTY/TTD: 1-303-894-7880
http://cdn.colorado.gov/cs/Satellite/DORA-HealthIns/CBON/DORA/1251645703837

Connecticut

CHOICES

55 Farmington Ave
Hartford, CT 06105-3730
1-860-424-5274 TTY/TTD: 711
www.ct.gov/agingservices

Delaware

Delaware Medicare Assistance Bureau

841 Silver Lake Boulevard
Dover, DE 19904
1-800-336-9500 TTY/TTD: 711
www.delawareinsurance.gov/elderinfo/

SECTION 1 State Health Insurance Assistance Program (SHIP) (con't)

District of Columbia

Health Insurance Counseling Project (HICP)

650 20th Street NW
Washington, DC 20052

1-202-994-6272 TTY/TTD: 1-202-994-6656
http://dcoa.dc.gov/service/health-insurance-counseling

Florida

Serving Health Insurance Needs of Elders (SHINE)

4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000

1-800-963-5337 TTY/TTD: 1-800-955-8770
www.floridashine.org

Georgia

GeorgiaCares

2 Peachtree Street NW
33rd Floor
Atlanta, GA 30303

1-866-552-4464 TTY/TTD: 711
www.mygeorgiacares.org

Hawaii

HAWAII SHIP

250 S Hotel Street
Suite 406
Honolulu, HI 96813-2831

1-888-875-9229 TTY/TTD: 1-866-810-4379
http://www.hawaiiship.org/site/1/home.aspx

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)

700 West State
St. 3rd floor
Boise, ID 83702-0043

1-800-247-4422 TTY/TTD: 711
http://www.doi.idaho.gov/shiba/shibahealth.aspx

Illinois

Senior Health Insurance Program (SHIP)

One Natural Resources Way, #100
Springfield, IL 62702-1271

1-800-252-8966 TTY/TTD: 711
http://www.state.il.us/aging/SHIP/default.htm

Indiana

State Health Insurance Assistance Program (SHIP)

714 W 53rd St
Anderson, IN 46013

1-800-452-4800 TTY/TTD: 711
www.medicare.in.gov

Iowa

Senior Health Insurance Information Program (SHIIP)

601 Locust Street
4th Floor
Des Moines, IA 50309-3738

1-800-351-4664 TTY/TTD: 1-800-735-2942
www.shiip.state.ia.us/

SECTION 1 State Health Insurance Assistance Program (SHIP) (con't)

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)

503 S. Kansas Ave
New England Bldg
Topeka, KS 66603-3404

1-800-860-5260 TTY/TTD: 711
http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick

Kentucky

State Health Insurance Assistance Program (SHIP)

275 E. Main St.
Frankfort, KY 40621

1-877-293-7447 TTY/TTD: 711
www.chfs.ky.gov/dail/ship.htm

Louisiana

Senior Health Insurance Information Program (SHIIP)

1702 N. Third Street
P.O. Box 94214
Baton Rouge, LA 70802

1-800-259-5300 TTY/TTD: 711
www.ldi.la.gov/SHIIP

Maine

Maine State Health Insurance Assistance Program (SHIP)

11 State House Station 41 Anthony Ave
Augusta, ME 04333

1-877-353-3771 TTY/TTD: 711
www.maine.gov/dhhs/oads/aging/community/ship.shtml

Maryland

Senior Health Insurance Assistance Program (SHIP)

301 W. Preston Street
Suite 1007
Baltimore, MD 21201

1-800-243-3425 TTY/TTD: 711
http://www.aging.maryland.gov/StateHealthInsuranceProgram.html

Massachusetts

Serving Health Information Needs of Elders (SHINE)

1 Ashburton Place
5th floor
Boston, MA 02108

1-800-243-4636 TTY/TTD: 1-800-872-0166
http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html

Michigan

MMAP, Inc.

6105 W St. Joseph
Suite 204
Lansing, MI 48917

1-800-803-7174 TTY/TTD: 711
www.mmapinc.org

Minnesota

Minnesota State Health Insurance Assistance Program/Senior LinkAge Line

P.O. Box 64976
St. Paul, MN 55164-0976

1-800-333-2433 TTY/TTD: 1-800-627-3529
www.mnaging.org

SECTION 1 State Health Insurance Assistance Program (SHIP) (con't)

Mississippi

MS State Health Insurance Assistance Program (SHIP)

750 North State Street
Jackson, MS 39202

1-800-948-3090 TTY/TTD: 711
http://www.mdhs.state.ms.us/programs-services-for-seniors/state-health-insurance-assistance-program/

Missouri

CLAIM

200 North Keene Street
Suite 101
Columbia, MO 65201

1-800-390-3330 TTY/TTD: 711
www.missouriclaim.org

Montana

Montana State Health Insurance Assistance Program (SHIP)

2030 11th Ave
Helena, MT 59601

1-800-551-3191 TTY/TTD: 711
http://dphhs.mt.gov/SLTC/aging/SHIP

Nebraska

Nebraska Senior Health Insurance Information Program (SHIIP)

941 O Street
Suite 400
Lincoln, NE 68508

1-800-234-7119 TTY/TTD: 711
www.doi.ne.gov/shiip

Nevada

State Health Insurance Assistance Program (SHIP)

3416 Goni Road
Suite D-132
Carson City, NV 89706

1-800-307-4444 TTY/TTD: 711
http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/

New Hampshire

NH SHIP - ServiceLink Resource Center

129 Pleasant Street
Gallen State Office Park
Concord, NH 03301-3857

1-866-634-9412 TTY/TTD: 711
www.servicelink.org

New Jersey

State Health Insurance Assistance Program (SHIP)

P.O. Box 360
Trenton, NJ 08625-0715

1-800-792-8820 TTY/TTD: 711
www.state.nj.us/humanservices/doas/services/ship/

New Mexico

Benefits Counseling Program

2550 Cerrillos Road
Santa Fe, NM 87505

1-800-432-2080 TTY/TTD: 711
http://www.nmaging.state.nm.us/State_Health_Insurance_Assistance_Program.aspx

SECTION 1 State Health Insurance Assistance Program (SHIP) (con't)

New York

Health Insurance Information Counseling and Assistance Program (HIICAP)

2 Empire State Plaza
Albany, NY 12223-1251
1-800-701-0501 TTY/TTD: 711
www.aging.ny.gov/HealthBenefits/Index.cfm

North Carolina

Seniors' Health Insurance Information Program (SHIIP)

11 South Boylan Avenue
Raleigh, NC 27603
1-855-408-1212 TTY/TTD: 711
http://www.ncdoi.com/SHIIP/

North Dakota

Senior Health Insurance Counseling (SHIC)

600 East Boulevard Ave
5th Floor
Bismarck, ND 58505-0320
1-888-575-6611 TTY/TTD: 1-800-366-6888
http://www.nd.gov/ndins/shic/

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)

50 West Town Street
3rd Floor - Suite 300
Columbus, OH 43215
1-800-686-1578 TTY/TTD: 1-614-644-3745
http://www.insurance.ohio.gov/Consumer/Pages/ConsumerTab2.aspx

Oklahoma

Senior Health Insurance Counseling Program (SHIP)

3625 NW 56th St
Suite 100
Oklahoma City, OK 73112
1-800-763-2828 TTY/TTD: 711
http://www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html

Oregon

Senior Health Insurance Benefits Assistance Program (SHIBA)

350 Winter Street NE
Suite 330, P.O. Box 14480
Salem, OR 97309-0405
1-800-722-4134 TTY/TTD: 711
http://www.oregon.gov/dcbs/insurance/SHIBA/Pages/shiba.aspx

Pennsylvania

APPRISE

555 Walnut Street
5th Floor
Harrisburg, PA 17101-1919
1-800-783-7067 TTY/TTD: 711
www.portal.state.pa.us/portal/server.pt?ope

Rhode Island

Senior Health Insurance Program (SHIP)

Hazard Building
74 West Road
Cranston, RI 02920
1-401-462-0510 TTY/TTD: 1-401-462-0740
http://www.dea.ri.gov/insurance/

SECTION 1 State Health Insurance Assistance Program (SHIP) (con't)

South Carolina

(I-CARE) Insurance Counseling Assistance and Referrals for Elders

1301 Gervais Street
Suite 350
Columbia, SC 29201

1-800-868-9095 TTY/TTD: 711
http://aging.sc.gov/programs/medicare/Pages/default.aspx

South Dakota

Senior Health Information & Insurance Education (SHIINE)

700 Governors Drive
Pierre, SD 57501

1-800-536-8197 TTY/TTD: 711
www.shiine.net

Tennessee

TN SHIP

500 Deaderick Street
Suite 825
Nashville, TN 37243-0860

1-877-801-0044 TTY/TTD: 711
http://www.tnmedicarehelp.com/

Texas

Health Information Counseling and Advocacy Program (HICAP)

701 W 51st Street
Austin, TX 78751

1-855-937-2372 TTY/TTD: 711
http://www.dads.state.tx.us

Utah

Senior Health Insurance Information Program (SHIP)

195 North 1950 West
Salt Lake City, UT 84116

1-800-541-7735 TTY/TTD: 711
http://daas.utah.gov/senior-services/

Vermont

State Health Insurance Assistance Program

481 Summer Street
Suite 101
St. Johnsbury, VT 05819

1-800-642-5119 TTY/TTD: 711
www.medicarehelpvt.net/

Virginia

Virginia Insurance Counseling and Assistance Program (VICAP)

1610 Forest Avenue
Suite 100
Henrico, VA 23229

1-800-552-3402 TTY/TTD: 711
www.vda.virginia.gov

Washington

Statewide Health Insurance Benefits Advisors (SHIBA) Helpline

P.O. Box 40256
Olympia, WA 98504-0256

1-800-562-6900 TTY/TTD: 711
http://www.insurance.wa.gov

SECTION 1 State Health Insurance Assistance Program (SHIP) (con't)

West Virginia

West Virginia State Health Insurance Assistance Program (WV SHIP)

1900 Kanawha Blvd. E
Charleston, WV 25305

1-877-987-4463 TTY/TTD: 711

www.wvship.org

Wisconsin

Wisconsin SHIP (SHIP)

One West Wilson St.
Madison, WI 53703

1-800-242-1060 TTY/TTD: 711

https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)

106 W Adams
PO Box BD
Riverton, WY 82501

1-800-856-4398 TTY/TTD: 711

www.wyomingseniors.com

SECTION 2 Quality Improvement Organization (QIO)

Alabama

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Alaska

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-877-588-1123 TTY/TTD: 1-877-588-1123
www.BFCCQIOAREA5.com

Arizona

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-877-588-1123 TTY/TTD: 1-877-588-1123
www.BFCCQIOAREA5.com

Arkansas

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

California

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-877-588-1123 TTY/TTD: 1-877-588-1123
www.BFCCQIOAREA5.com

Colorado

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Connecticut

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

Delaware

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

District of Columbia

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Florida

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

SECTION 2 Quality Improvement Organization (QIO) (con't)

Georgia

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Hawaii

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-877-588-1123 TTY/TTD: 1-877-588-1123
www.BFCCQIOAREA5.com

Idaho

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-877-588-1123 TTY/TTD: 1-877-588-1123
www.BFCCQIOAREA5.com

Illinois

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Indiana

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Iowa

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Kansas

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Kentucky

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Louisiana

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Maine

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

SECTION 2 Quality Improvement Organization (QIO) (con't)

Maryland

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Massachusetts

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

Michigan

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Minnesota

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Mississippi

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Missouri

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Montana

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Nebraska

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Nevada

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-877-588-1123 TTY/TTD: 1-877-588-1123
www.BFCCQIOAREA5.com

New Hampshire

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

SECTION 2 Quality Improvement Organization (QIO) (con't)

New Jersey

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

New Mexico

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

New York

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

North Carolina

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

North Dakota

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Ohio

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Oklahoma

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Oregon

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-877-588-1123 TTY/TTD: 1-877-588-1123
www.BFCCQIOAREA5.com

Pennsylvania

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

Rhode Island

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

SECTION 2 Quality Improvement Organization (QIO) (con't)

South Carolina

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

South Dakota

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Tennessee

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Texas

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Utah

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131
1-844-430-9504 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Vermont

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-866-815-5440 TTY/TTD: 1-866-868-2289
www.BFCCQIOAREA1.com

Virginia

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Washington

BFCC-QIO Program

9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701
1-877-588-1123 TTY/TTD: 1-877-588-1123
www.BFCCQIOAREA5.com

West Virginia

KEPRO - Area 2

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-844-455-8708 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

Wisconsin

KEPRO - Area 4

5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609
1-855-408-8557 TTY/TTD: 1-855-843-4776
www.keproqio.com/default.aspx

SECTION 2 Quality Improvement Organization (QIO) (con't)

Wyoming

KEPRO - Area 3

5700 Lombardo Center Dr.
Suite 100
Seven Hills, OH 44131

1-844-430-9504 TTY/TTD: 1-855-843-4776

www.keproqio.com/default.aspx

SECTION 3 State Medicaid Offices

Alabama

Alabama Medicaid Agency

PO Box 5624
Montgomery, AL 36103-5624
(866) 452-4930 TTY/TTD: 711
www.medicaid.alabama.gov

Alaska

Alaska Medicaid

3601 C Street Suite 200
Anchorage, AK 99503
(800) 478-6406 TTY/TTD: 711
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Arizona

Arizona Health Care Cost Containment System

801 E. Jefferson, MD 4100
Phoenix, AZ 85034
1-800-523-0231 TTY/TTD: 711
http://www.azahcccs.gov

Arkansas

Arkansas Medicaid

Donaghey Plaza South
P.O. Box 1437 Slot S401
Little Rock, AR 72203-1437
1-800-482-5431 TTY/TTD: 711
www.medicaid.state.ar.us

California

Medi-Cal

P.O. Box 997417, MS 4607
Sacramento, CA 95899-7413
1-916-552-9200 TTY/TTD: 711
www.medi-cal.ca.gov

Colorado

Colorado Medicaid

1570 Grant Street
Denver, CO 80203
1-800-221-3943 TTY/TTD: 711
https://www.colorado.gov/hcpf

Connecticut

HUSKY Health

55 Farmington Avenue
Hartford, CT 06105-3730
1-877-284-8759 TTY/TTD: 1-866-492-5276
http://www.huskyhealth.com/hh/site/default.asp

Delaware

Delaware Medicaid

Lewis Building
1901 N. DuPont Highway
New Castle, DE 19720
1-800-372-2022 TTY/TTD: 711
www.dhss.delaware.gov/dhss/dmma/medicaid.html

District of Columbia

DC Medicaid

899 North Capitol Street, NE
Suite 6039
Washington, DC 20002
1-202-442-5988 TTY/TTD: 711
https://dchealthlink.com/medicaid

SECTION 3 State Medicaid Offices (con't)

Florida

Florida Medicaid

2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 TTY/TTD: 711
www.ahca.myflorida.com/Medicaid/index.shtml/about

Georgia

Georgia Medicaid

2 Peachtree Street, NW
Atlanta, GA 30303
1-866-211-0950 TTY/TTD: 711
http://dch.georgia.gov/medicaid

Hawaii

Quest Integration

601 Kamokila Blvd
Room 395
Kapolei, HI 96707
1-800-316-8005 TTY/TTD: 711
http://www.med-quest.us

Idaho

Idaho Medicaid

1720 West Gate Dr
Boise, ID 83704
1-877-456-1233 TTY/TTD: 711
http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx

Illinois

Illinois Medicaid

201 South Grand Avenue East
Springfield, IL 62763
1-800-226-0768 TTY/TTD: 711
http://www.hfs.illinois.gov/medical/apply.html/

Indiana

Indiana Medicaid

402 W. Washington St.
P.O. Box 7083
Indianapolis, IN 46207-7083
1-800-457-4584 TTY/TTD: 711
http://member.indianamedicaid.com/

Iowa

Iowa Medicaid

Hoover State Office Building, 5th Floor
1305 E. Walnut Street
Des Moines, IA 50319-0114
1-800-338-8366 TTY/TTD: 1-800-735-2942
www.dhs.iowa.gov

Kansas

KanCare

120 SW 10th Avenue, 2nd Floor
Topeka, KS 66612
1-866-305-5147 TTY/TTD: 1-800-766-3777
www.kancare.ks.gov/index.htm

Kentucky

Kentucky Medicaid

275 East Main Street
Frankfort, KY 40621
1-800-635-2570 TTY/TTD: 711
www.chfs.ky.gov

Louisiana

Louisiana Medicaid

P. O. Box 629
Baton Rouge, LA 70821-0629
1-888-342-6207 TTY/TTD: 711
new.dhh.louisiana.gov/index.cfm/subhome/1

SECTION 3 State Medicaid Offices (con't)

Maine

MaineCare

11 State House Station
Augusta, ME 04333-0011

1-800-977-6740 TTY/TTD: 711
www.maine.gov/dhhs/oms/index.shtml

Maryland

Maryland Medicaid

201 West Preston Street
Baltimore, MD 21201

1-800-492-5231 TTY/TTD: 711
https://mmcp.dhmh.maryland.gov/SitePages/Medicaid%20Medical%20Assistance%20Overview.aspx

Massachusetts

MassHealth

One Ashburton Place
11th Floor
Boston, MA 02108

1-800-841-2900 TTY/TTD: 1-800-497-4648
www.mass.gov/eohhs/gov/departments/masshealth/

Michigan

Michigan Medicaid

Capital View Building
201 Townsend St
Lansing, MI 48913

(855) 643-7283 TTY/TTD: 711
http://www.michigan.gov/mdch/0,4612,7-132-2943_4860---,00.html

Minnesota

Minnesota's Medical Assistance Program

P.O. Box 64838
St. Paul, MN 55164

1-800-657-3739 TTY/TTD: 711
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006254

Mississippi

Mississippi Medicaid

550 High Street Suite 1000
Jackson, MS 39201

1-800-421-2408 TTY/TTD: 711
www.medicaid.ms.gov

Missouri

MO HealthNet

615 Howerton Ct
P.O. Box 6500
Jefferson City, MO 65102-6500

1-800-392-2161 TTY/TTD: 711
http://www.dss.mo.gov/fsd/index.htm

Montana

Montana Medicaid

1400 Broadway, Cogswell Building
P.O. Box 202951
Helena, MT 59620

1-800-362-8312 TTY/TTD: 711
www.dphhs.mt.gov

SECTION 3 State Medicaid Offices (con't)

Nebraska

Nebraska Medicaid

P.O. Box 95026
Lincoln, NE 68509-5026
1-877-255-3092 TTY/TTD: 711
www.dhhs.ne.gov/medicaid/Pages/medicaid.aspx

Nevada

Nevada Medicaid

1100 East William Street
Suite 101
Carson City, NV 89701
1-800-992-0900 TTY/TTD: 711
https://dhcfp.nv.gov/index.htm

New Hampshire

NH Medicaid

129 Pleasant Street
Concord, NH 03301
1-800-852-3345 TTY/TTD: 1-800-735-2964
http://www.dhhs.state.nh.us/ombp/medicaid/index.htm

New Jersey

NJ Medicaid

P.O. Box 712
Trenton, NJ 08625-0712
1-800-356-1561 TTY/TTD: 711
www.state.nj.us/humanservices/dmahs

New Mexico

Centennial Care

P.O. Box 2348
Sante Fe, NM 87504-2348
1-888-997-2583 TTY/TTD: 711
http://www.hsd.state.nm.us/LookingForAssistance/centennial-care-overview.aspx

New York

New York Medicaid

Corning Tower
Empire State Plaza
Albany, NY 12237
1-800-541-2831 TTY/TTD: 711
http://www.health.ny.gov/health_care/medicaid/

North Carolina

NC Division of Medical Assistance

2501 Mail Service Center
Raleigh, NC 27699-2501
1-800-662-7030 TTY/TTD: 711
http://www.ncdhhs.gov/dma/medicaid/

North Dakota

North Dakota Medicaid

600 E. Boulevard Avenue
Dept 325
Bismarck, ND 58505-0250
1-800-755-2604 TTY/TTD: 711
www.nd.gov/dhs/services/medicalserv/medicaid/

Ohio

Ohio Medicaid

50 West Town Street, Suite 400
Columbus, OH 43215
1-800-324-8680 TTY/TTD: 1-800-292-3572
http://medicaid.ohio.gov/

SECTION 3 State Medicaid Offices (con't)

Oklahoma

SoonerCare

4345 N. Lincoln Blvd
Oklahoma City, OK 73105

1-800-987-7767 TTY/TTD: 711
http://www.okhca.org/individuals.aspx?id=52&menu=40&parts=11601_7453

Oregon

Oregon Health Plan

Division of Medical Assistance Programs
500 Summer Street NE
Salem, OR 97301-1079

1-800-273-0557 TTY/TTD: 711
http://www.oregon.gov/oha/healthplan/pages/index.aspx

Pennsylvania

Pennsylvania Medical Assistance

Health and Welfare Building, Rm 515
P.O. Box 2675
Harrisburg, PA 17105

1-800-692-7462 TTY/TTD: 1-800-451-5886
https://www.compass.state.pa.us/compass.web/CMHOM.aspx

Rhode Island

Rhode Island Medicaid

Louis Pasteur Building
57 Howard Avenue
Cranston, RI 02920

1-855-840-4774 TTY/TTD: 1-888-657-3173
http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/Elders.aspx

South Carolina

Healthy Connections

P.O. Box 8206
Columbia, SC 29202

1-888-549-0820 TTY/TTD: 711
https://www.scdhhs.gov/

South Dakota

South Dakota Medicaid

700 Governors Drive
Richard F Kneip Bldg
Pierre, SD 57501

1-800-597-1603 TTY/TTD: 711
http://dss.sd.gov/medicaid

Tennessee

TennCare

310 Great Circle Rd.
Nashville, TN 37243

1-855-259-0701 TTY/TTD: 1-877-779-3103
http://state.tn.us/tenncare

Texas

Texas Medicaid

4900 N. Lamar Boulevard
Austin, TX 78751

1-800-252-8263 TTY/TTD: 711
http://www.hhsc.state.tx.us/medicaid/index.shtml

Utah

Utah Medicaid

Division of Medicaid and Health Financing

P.O. Box 143106
Salt Lake City, UT 84114

1-801-538-6155 TTY/TTD: 711
https://medicaid.utah.gov/

SECTION 3 State Medicaid Offices (con't)

Vermont

Vermont's MABD Medicaid

103 South Main Street
Waterbury, VT 05671-1500

1-800-250-8427 TTY/TTD: 1-888-834-7898
http://www.greenmountaincare.org/vermont-health-insurance-plans/medicaid

Virginia

Virginia Medicaid

801 E. Main Street
Richmond, VA 23219-2901

1-855-242-8282 TTY/TTD: 1-800-343-0634
http://www.dss.virginia.gov/benefit/medical_assistance/index.cgi/

Washington

Washington Apple Health

P.O. Box 45502
Olympia, WA 98504-5502

1-800-562-6900 TTY/TTD: 1-800-848-5429
http://www.hca.wa.gov/medicaid/Pages/index.aspx

West Virginia

West Virginia Medicaid

WV Bureau for Medical Services

350 Capital Street Room 251
Charleston, WV 25301-3709

1-888-483-0797 TTY/TTD: 711
http://www.dhhr.wv.gov/bms/Pages/default.aspx

Wisconsin

Wisconsin Medicaid

1 West Wilson Street
Madison, WI 53703

1-800-362-3002 TTY/TTD: 711
http://www.dhfs.state.wi.us/medicaid/index.htm

Wyoming

Wyoming Medicaid

6101 Yellowstone Rd.
Suite 259D
Cheyenne, WY 82002

1-855-294-2127 TTY/TTD: 1-855-329-5204
health.wyo.gov

SECTION 4 State Medicare Offices

Alabama

Centers for Medicare & Medicaid Services

Atlanta Regional Office
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Alaska

Centers for Medicare & Medicaid Services

Seattle Regional Office
2201 Sixth Ave., Ms/Rx-44
Seattle, WA 98121

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Arizona

Centers for Medicare & Medicaid Services

San Francisco Regional Office
90 - 7th Street, Suite 5-300
San Francisco, CA 94103

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Arkansas

Centers for Medicare & Medicaid Services

Dallas Regional Office
1301 Young Street, Room 714
Dallas, TX 75202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

California

Centers for Medicare & Medicaid Services

San Francisco Regional Office
90 - 7th Street, Suite 5-300
San Francisco, CA 94103

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Colorado

Centers for Medicare & Medicaid Services

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Connecticut

Centers for Medicare & Medicaid Services

Boston Regional Office
JFK Federal Building, Room 2325
Boston, MA 02203-0003

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Delaware

Centers for Medicare & Medicaid Services

Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

District of Columbia

Centers for Medicare & Medicaid Services

Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Florida

Centers for Medicare & Medicaid Services

Atlanta Regional Office
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

SECTION 4 State Medicare Offices (con't)

Georgia

Centers for Medicare & Medicaid Services

Atlanta Regional Office
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303-8909

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Hawaii

Centers for Medicare & Medicaid Services

San Francisco Regional Office
90 - 7th Street, Suite 5-300
San Francisco, CA 94103

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Idaho

Centers for Medicare & Medicaid Services

Seattle Regional Office
2201 Sixth Ave., Ms/Rx-44
Seattle, WA 98121

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Illinois

Centers for Medicare & Medicaid Services

Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Indiana

Centers for Medicare & Medicaid Services

Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Iowa

Centers for Medicare & Medicaid Services

Kansas City Regional Office
601 East 12th Street, Room 235
Kansas City, MO 64106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Kansas

Centers for Medicare & Medicaid Services

Kansas City Regional Office
601 East 12th Street, Room 235
Kansas City, MO 64106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Kentucky

Centers for Medicare & Medicaid Services

Atlanta Regional Office
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Louisiana

Centers for Medicare & Medicaid Services

Dallas Regional Office
1301 Young Street, Room 714
Dallas, TX 75202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Maine

Centers for Medicare & Medicaid Services

Boston Regional Office
JFK Federal Building, Room 2325
Boston, MA 02203-0003

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

SECTION 4 State Medicare Offices (con't)

Maryland

Centers for Medicare & Medicaid Services

Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Massachusetts

Centers for Medicare & Medicaid Services

Boston Regional Office
JFK Federal Building, Room 2325
Boston, MA 02203-0003

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Michigan

Centers for Medicare & Medicaid Services

Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

1-800-633-4227 TTY/TTD: 1-877-486-2048
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Minnesota

Centers for Medicare & Medicaid Services

Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Mississippi

Centers for Medicare & Medicaid Services

Atlanta Regional Office
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303-8909

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Missouri

Centers for Medicare & Medicaid Services

Kansas City Regional Office
601 East 12th Street, Room 235
Kansas City, MO 64106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Montana

Centers for Medicare & Medicaid Services

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Nebraska

Centers for Medicare & Medicaid Services

Kansas City Regional Office
601 East 12th Street, Room 235
Kansas City, MO 64106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Nevada

Centers for Medicare & Medicaid Services

San Francisco Regional Office
90 - 7th Street, Suite 5-300
San Francisco, CA 94103

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

New Hampshire

Centers for Medicare & Medicaid Services

Boston Regional Office
JFK Federal Building, Room 2325
Boston, MA 02203-0003

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

SECTION 4 State Medicare Offices (con't)

New Jersey

Centers for Medicare & Medicaid Services

New York Regional Office
26 Federal Plaza, Room 3811
New York, NY 10278

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

New Mexico

Centers for Medicare & Medicaid Services

Dallas Regional Office
1301 Young Street, Room 714
Dallas, TX 75202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

New York

Centers for Medicare & Medicaid Services

New York Regional Office
26 Federal Plaza, Room 3811
New York, NY 10278

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

North Carolina

Centers for Medicare & Medicaid Services

Atlanta Regional Office
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

North Dakota

Centers for Medicare & Medicaid Services

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Ohio

Centers for Medicare & Medicaid Services

Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Oklahoma

Centers for Medicare & Medicaid Services

Dallas Regional Office
1301 Young Street, Room 714
Dallas, TX 75202

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Oregon

Centers for Medicare & Medicaid Services

Seattle Regional Office
2201 Sixth Ave., Ms/Rx-44
Seattle, WA 98121

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Pennsylvania

Centers for Medicare & Medicaid Services

Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Rhode Island

Centers for Medicare & Medicaid Services

Boston Regional Office
JFK Federal Building, Room 2325
Boston, MA 02203-0003

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

SECTION 4 State Medicare Offices (con't)

South Carolina

Centers for Medicare & Medicaid Services

Atlanta Regional Office
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

South Dakota

Centers for Medicare & Medicaid Services

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Tennessee

Centers for Medicare & Medicaid Services

Atlanta Regional Office
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303

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www.medicare.gov

Texas

Centers for Medicare & Medicaid Services

Dallas Regional Office
1301 Young Street, Room 714
Dallas, TX 75202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Utah

Centers for Medicare & Medicaid Services

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Vermont

Centers for Medicare & Medicaid Services

Boston Regional Office
JFK Federal Building, Room 2325
Boston, MA 02203-0003

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Virginia

Centers for Medicare & Medicaid Services

Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Washington

Centers for Medicare & Medicaid Services

Seattle Regional Office
2201 Sixth Ave., Ms/Rx-44
Seattle, WA 98121

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www.medicare.gov

West Virginia

Centers for Medicare & Medicaid Services

Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

Wisconsin

Centers for Medicare & Medicaid Services

Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

SECTION 4 State Medicare Offices (con't)

Wyoming

Centers for Medicare & Medicaid Services

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

1-800-633-4227 TTY/TTD: 1-877-486-2048
www.medicare.gov

SECTION 5 State Pharmaceutical Assistance Program (SPAP)

Connecticut

ConnPace

P.O. Box 5011
Hartford, CT 06102-5011

1-800-423-5026 TTY/TTD: 711
http://www.ct.gov/dss/cwp/view.asp?Q=450668&A=2345

Delaware

Delaware Prescription Assistance Program

P.O. Box 950
New Castle, DE 19720-0950

1-800-996-9969 TTY/TTD: 711
http://www.dhss.delaware.gov/dhss/dmma/dpap.html

Indiana

HoosierRx

P.O. Box 6224
Indianapolis, IN 46206-6224

1-866-267-4679 TTY/TTD: 711
http://www.in.gov/fssa/ompp/2669.htm

Maine

Office of Elder Services - Maine Low Cost Drugs for the Elderly or Disabled Program

242 State Street
Augusta, ME 04333

1-866-796-2463 TTY/TTD: 711
www.maine.gov/dhhs/beas/resource/lc_drugs.htm

Maryland

Maryland SDPAP c/o Pool Administrators

628 Hebron Ave, Suite 212
Glastonbury, CT 06033

1-800-551-5995 TTY/TTD: 1-800-877-5156
www.marylandspdap.com

Massachusetts

Massachusetts Prescription Advantage

P.O. Box 15153
Worcester, MA 01615

1-800-243-4636 TTY/TTD: 1-877-610-0241
www.mass.gov/elders/healthcare/prescription-advantage/

Missouri

Missouri Rx Plan

P.O. Box 6500
Jefferson City, MO 65102

1-800-375-1406 TTY/TTD: 711
www.morx.mo.gov

Montana

Big Sky Rx Program

P.O. Box 202915
Helena, MT 59620-2915

1-866-369-1233 TTY/TTD: 711
http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx

Nevada

Aging and Disability Services Division – Senior Rx and Disability Rx

Aging and Disability Services Division - Senior Rx and Disability Rx
3416 Goni Road, Suite D-132
Carson City, NV 89706

1-866-303-6323 TTY/TTD: 711
http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/

SECTION 5 State Pharmacy Assistance Program (SPAP) (con't)

New Jersey

New Jersey State Pharmaceutical Assistance Programs - PAAD and Senior Gold

12B Quakerbridge Plaza
P.O. Box 715
Trenton, NJ 08625-0715

1-800-792-9745 TTY/TTD: 711
http://www.state.nj.us/humanservices/doas/home/pbp.html

New York

New York State Elderly Pharmaceutical Insurance Coverage (EPIC)

P.O. Box 15018
Albany, NY 12212-5018

1-800-332-3742 TTY/TTD: 711
www.health.ny.gov/health_care/epic

Pennsylvania

Pennsylvania Department of Aging Bureau of Pharmaceutical Assistance

P.O. Box 8806
Harrisburg, PA 17105

1-800-225-7223 TTY/TTD: 1-800-222-9004
www.aging.state.pa.us/portal/server.pt/community/pace_and_affordable_medications/17942

Rhode Island

Rhode Island Prescription Assistance for the Elderly (RIPAE)

Attention RIPAE, Rhode Island Department of Elderly Affairs
74 West Road, Hazard Building, Second Floor
Cranston, RI 02920

1-401-462-3000 TTY/TTD: 1-401-462-0740
www.dea.state.ri.us/programs/prescription_assist.php

Texas

Kidney Health Care Program

Department of State Health Services, MC 1938
PO Box 149347
Austin, TX 78714-9347

1-800-222-3986 TTY/TTD: 711
http://www.dshs.state.tx.us/kidney/default.shtm

Vermont

Vermont VPharm

312 Hurricane Lane
Suite 201
Willston, VT 05495

1-800-250-8427 TTY/TTD: 1-888-834-7898
http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance

Washington

Washington State Health Insurance Pharmacy Assistance Program

P.O. Box 1090
Great Bend, KS 67530

1-800-877-5187 TTY/TTD: 711
www.wship.org/default.asp

Wisconsin

Wisconsin Senior Care

P.O. Box 6710
Madison, WI 53716

1-800-657-2038 TTY/TTD: 711
www.dhfs.state.wi.us/seniorcare/index.htm

SECTION 6 Civil Rights Commission

Alabama

Office for Civil Rights of the Southeast

61 Forsyth Street, SW
Suite 16T70
Atlanta, GA 30303

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-404-562-7881
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Alaska

Office for Civil Rights of Alaska, Idaho, Oregon, and Washington

701 Fifth Avenue, Suite 1600
MS - 11
Seattle, WA 98104

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-206-615-2297
Email: ocrmail@of.dhhs.gov
www.hhs.gov/ocr

Arizona

Office for Civil Rights of the West

90 7th Street
Suite 4-100
San Francisco, CA 94103

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-415-437-8329
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Arkansas

Office for Civil Rights of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

1301 Young Street
Suite 1169
Dallas, TX 75202

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-214-767-0432
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

California

Office for Civil Rights of the West

90 7th Street
Suite 4-100
San Francisco, CA 94103

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-415-437-8329
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Colorado

Office for Civil Rights of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

999 18th Street
Suite 417
Denver, CO 80202

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-303-844-2025
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

SECTION 6 Civil Rights Commission (con't)

Connecticut

Office for Civil Rights of New England

JFK Federal Building
Room 1875
Boston, MA 02203

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-617-565-3809
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Delaware

Office for Civil Rights of the Mid-Atlantic

150 South Independence Mall West
Public Ledger Building - Suite 372
Philadelphia, PA 19106

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-215-861-4431
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

District of Columbia

Office for Civil Rights of the Mid-Atlantic

150 South Independence Mall West
Public Ledger Building - Suite 372
Philadelphia, PA 19106

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-215-861-4431
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Florida

Office for Civil Rights of the Southeast

61 Forsyth Street, SW
Suite 16T70
Atlanta, GA 30303

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-404-562-7881
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Georgia

Office for Civil Rights of the Southeast

61 Forsyth Street, SW
Suite 16T70
Atlanta, GA 30303

1-800-368-1019 TTY/TTD: 1-800-537-7697
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www.hhs.gov/ocr

Hawaii

Office for Civil Rights of the West

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San Francisco, CA 94103

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Fax: 1-415-437-8329
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Idaho

Office for Civil Rights of Alaska, Idaho, Oregon, and Washington

701 Fifth Avenue, Suite 1600
MS-11
Seattle, WA 98104

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-206-615-2297
Email: ocrmail@of.dhhs.gov
www.hhs.gov/ocr

Illinois

Office for Civil Rights of the Mid-West

233 N Michigan Ave
Suite 240
Chicago, IL 60601

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-312-886-1807
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

SECTION 6 Civil Rights Commission (con't)

Indiana

Office for Civil Rights of the Mid-West

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Suite 240
Chicago, IL 60601

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Fax: 1-312-886-1807
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Iowa

Office for Civil Rights of Iowa, Kansas, Missouri, and Nebraska

601 East 12th Street
Room 353
Kansas City, MO 64106

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-816-426-3686
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Kansas

Office for Civil Rights of Iowa, Kansas, Missouri, and Nebraska

601 East 12th Street
Room 353
Kansas City, MO 64106

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-816-426-3686
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Kentucky

Office for Civil Rights of the Southeast

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Atlanta, GA 30303

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-404-562-7881
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Louisiana

Office for Civil Rights of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

1301 Young Street
Suite 1169
Dallas, TX 75202

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-214-767-0432
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Maine

Office for Civil Rights of New England

JFK Federal Building
Room 1875
Boston, MA 02203

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-617-565-3809
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

SECTION 6 Civil Rights Commission (con't)

Maryland

Office for Civil Rights of the Mid-Atlantic

150 South Independence Mall West
Public Ledger Building - Suite 372
Philadelphia, PA 19106

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Fax: 1-215-861-4431
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www.hhs.gov/ocr

Massachusetts

Office for Civil Rights of New England

JFK Federal Building
Room 1875
Boston, MA 02203

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-617-565-3809
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Michigan

Office for Civil Rights of the Mid-West

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Suite 240
Chicago, IL 60601

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Minnesota

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Email: ocrmail@hhs.gov
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Mississippi

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Missouri

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Fax: 1-816-426-3686
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

SECTION 6 Civil Rights Commission (con't)

Montana

Office for Civil Rights of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

999 18th Street
Suite 417
Denver, CO 80202
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-303-844-2025
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Nebraska

Office for Civil Rights of Iowa, Kansas, Missouri, and Nebraska

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Kansas City, MO 64106
1-800-368-1019 TTY/TTD: 1-800-537-7697
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Nevada

Office for Civil Rights of the West

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Fax: 1-415-437-8329
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

New Hampshire

Office for Civil Rights of New England

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Boston, MA 02203
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-617-565-3809
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

New Jersey

Office for Civil Rights of New Jersey, New York, Puerto Rico, and Virgin Islands

26 Federal Plaza
Suite 3312
New York, NY 10278
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-212-264-3039
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

New Mexico

Office for Civil Rights of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

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Dallas, TX 75202
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-214-767-0432
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www.hhs.gov/ocr

SECTION 6 Civil Rights Commission (con't)

New York

Office for Civil Rights of New Jersey, New York, Puerto Rico, and Virgin Islands

26 Federal Plaza
Suite 3312
New York, NY 10278
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-212-264-3039
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

North Carolina

Office for Civil Rights of the Southeast

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Atlanta, GA 30303
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Fax: 1-404-562-7881
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

North Dakota

Office for Civil Rights of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

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Fax: 1-303-844-2025
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Ohio

Office for Civil Rights of the Mid-West

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Fax: 1-312-886-1807
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Oklahoma

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Fax: 1-214-767-0432
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Oregon

Office for Civil Rights of Alaska, Idaho, Oregon, and Washington

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Seattle, WA 98104
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Fax: 1-206-615-2297
Email: ocrmail@of.dhhs.gov
www.hhs.gov/ocr

SECTION 6 Civil Rights Commission (con't)

Pennsylvania

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Fax: 1-215-861-4431
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Rhode Island

Office for Civil Rights of New England

JFK Federal Building
Room 1875
Boston, MA 02203

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-617-565-3809
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

South Carolina

Office for Civil Rights of the Southeast

61 Forsyth Street, SW
Suite 16T70
Atlanta, GA 30303

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-404-562-7881
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

South Dakota

Office for Civil Rights of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

999 18th Street
Suite 417
Denver, CO 80202

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-303-844-2025
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Tennessee

Office for Civil Rights of the Southeast

61 Forsyth Street, SW
Suite 16T70
Atlanta, GA 30303

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-404-562-7881
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Texas

Office for Civil Rights of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

1301 Young Street
Suite 1169
Dallas, TX 75202

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-214-767-0432
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

SECTION 6 Civil Rights Commission (con't)

Utah

Office for Civil Rights of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

999 18th Street
Suite 417
Denver, CO 80202
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-303-844-2025
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Vermont

Office for Civil Rights of New England

JFK Federal Building
Room 1875
Boston, MA 02203
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-617-565-3809
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Virginia

Office for Civil Rights of the Mid-Atlantic

150 South Independence Mall West
Public Ledger Building - Suite 372
Philadelphia, PA 19106
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-215-861-4431
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Washington

Office for Civil Rights of Alaska, Idaho, Oregon, and Washington

701 Fifth Avenue, Suite 1600
MS - 11
Seattle, WA 98104
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-206-615-2297
Email: ocrmail@of.dhhs.gov
www.hhs.gov/ocr

West Virginia

Office for Civil Rights of the Mid-Atlantic

150 South Independence Mall West
Public Ledger Building - Suite 372
Philadelphia, PA 19106
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-215-861-4431
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

Wisconsin

Office for Civil Rights of the Mid-West

233 N Michigan Ave
Suite 240
Chicago, IL 60601
1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-312-886-1807
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

SECTION 6 Civil Rights Commission (con't)

Wyoming

Office for Civil Rights of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

999 18th Street
Suite 417
Denver, CO 80202

1-800-368-1019 TTY/TTD: 1-800-537-7697
Fax: 1-303-844-2025
Email: ocrmail@hhs.gov
www.hhs.gov/ocr

SECTION 7 AIDS Drug Assistance Program (ADAP)

Alabama

Alabama AIDS Drug Assistance Program

The RSA Tower, 201 Monroe St
Suite 1400
Montgomery, AL 36104
1-866-574-9964 TTY/TTD: 711
http://www.adph.org/aids/index.asp?id=995

Alaska

Alaska Health and Social Services - HIV Program

3601 "C" Street
Suite 540
Anchorage, AK 99503
1-907-269-8000 TTY/TTD: 711
Fax: 1-907-561-0453
http://www.epi.alaska.gov/hivstd/hiv.stm

Arizona

Arizona Department of Health Services

150 N. 18th Avenue
Suite 110
Phoenix, AZ 85007
1-800-334-1540 TTY/TTD: 711
Fax: 1-602-364-3263
http://www.azdhs.gov/phs/hiv/adap/

Arkansas

Arkansas Department of Health ADAP Program

4815 W. Markham
Little Rock, AR 72205
1-888-499-6544 TTY/TTD: 711
http://www.healthy.arkansas.gov/programsServices/infectiousDisease/hivStdHepatitisC/Pages/ADAP.aspx

California

California Office of AIDS

P.O. Box 997377
MS 0500
Sacramento, CA 95899-7377
1-916-558-1784 TTY/TTD: 1-800-735-2929
Fax: 1-916-449-5909
Email: ooa-web@cdph.ca.gov
www.cdph.ca.gov/programs/aids/Pages/tOAADAP.aspx

Colorado

Colorado Dept of Public Health and Environment

4300 Cherry Creek Drive S
Denver, CO 80246
1-303-692-2700 TTY/TTD: 711
https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap

Connecticut

CADAP

Department of Social Services, Medical Operations, Unit #4
55 Farmington Avenue
Hartford, CT 06106-3730
1-855-626-6632 TTY/TTD: 1-800-842-4524
http://www.ct.gov/dss

Delaware

AIDS Drug Assistance Program

540 S. DuPont Highway
Dover, DE 19901
1-302-744-1050 TTY/TTD: 711
Fax: 1-302-739-2548
http://dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html

SECTION 7 AIDS Drug Assistance Program (ADAP) (con't)

District of Columbia

DC AIDS Drug Assistance Program

889 North Capitol Street NE
Washington, DC 20002

1-202-671-4900 TTY/TTD: 711
Fax: 1-202-673-4365
Email: doh@dc.gov
http://doh.dc.gov/service/dc-aids-drug-assistance-program

Florida

Florida AIDS Drug Assistance Program

4052 Bald Cypress Way
Tallahassee, FL 32399

1-800-352-2437 TTY/TTD: 1-888-503-7118
Email: ADAPClientFeedback@doh.state.fl.us
http://www.floridahealth.gov/diseases-and-conditions/aids/adap/

Georgia

Georgia AIDS Drug Assistance Program

2 Peachtree Street NW
15th Floor
Atlanta, GA 30303-3186

1-404-657-2700 TTY/TTD: 711
http://dph.georgia.gov/hiv-care-services

Hawaii

HIV Drug Assistance Program

3627 Kilauea Avenue, Suite 306
Honolulu, HI 96816

1-808-733-9360 TTY/TTD: 711
http://health.hawaii.gov/std-aids/hiv-aids/hiv-programs/hiv-medical-management-services/

Idaho

Idaho HIV State Prescription Assistance Program

P. O. Box 83720
Boise, ID 83720

1-800-926-2588 TTY/TTD: 711
http://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx

Illinois

Illinois ADAP

525 W. Jefferson Street
First Floor
Springfield, IL 62761

1-217-782-3987 TTY/TTD: 711
Fax: 1-217-785-8013
http://www.idph.state.il.us/health/aids/adap.htm

Indiana

AIDS Drug Assistance Plan

2 North Meridian Street
Indianapolis, IN 46204

1-317-233-1325 TTY/TTD: 711
https://secure.in.gov/isdh/17740.htm

Iowa

AIDS Drug Assistance Program

321 E. 12th Street
Des Moines, IA 50319-0075

1-800-448-0440 TTY/TTD: 1-800 480-3739
http://www.idph.state.ia.us/HivStdHep/HIV-AIDS.aspx?prog=Hiv&pg=HivHome

SECTION 7 AIDS Drug Assistance Program (ADAP) (con't)

Kansas

Kancare and Medicaid

1000 SW Jackson, Suite 210
Topeka, Kansas 66612
1-785-296-6147 TTY/TTD: 711
Fax: 1-785-296-5590
http://www.kdheks.gov/sti_hiv/ryan_white_care.htm#ADAP

Kentucky

Kentucky AIDS Drug Assistance Program

275 E Main Street, HS2E-C
Frankfort, KY 40621
1-800-372-2973 TTY/TTD: 1-800-627-4702
http://chfs.ky.gov/dph/epi/HIVAIDS/

Louisiana

Louisiana Health Access Program

1450 Poydras Street
Suite 2136
New Orleans, LA 70112
1-504-568-7474 TTY/TTD: 711
Fax: 1-504-568-3157
Email: info@lahap.org
http://www.lahap.org/

Maine

Maine AIDS Drug Assistance Program

40 State House Station
Augusta, ME 04333
1-207-287-5539 TTY/TTD: 711
http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml

Maryland

Maryland AIDS Drug Assistance Program (MADAP)

201 W. Preston Street
Baltimore, MD 21201
1-800-205-6308 TTY/TTD: 711
http://phpa.dhmh.maryland.gov/OIDPCS/CHCS/SitePages/madap.aspx

Massachusetts

Massachusetts HIV Drug Assistance Program

38 Chauncy Street
Suite 500
Boston, MA 02111
1-800-228-2714 TTY/TTD: 711
http://www.mass.gov/eohhs/consumer/insurance/more-programs/prescription-drugs/

Michigan

Michigan Drug Assistance Program - HIV Care Section

109 Michigan Avenue
9th Floor
Lansing, MI 48913
1-888-826-6565 TTY/TTD: 711
Fax: 1-517-373-1495
http://michigan.gov/mdch/0,1607,7-132-2940_2955_2982-44913--,00.html

Minnesota

ADAP

P.O. Box 64972
St Paul, MN 55164-0972
1-800-657-3761 TTY/TTD: 711
http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp

SECTION 7 AIDS Drug Assistance Program (ADAP) (con't)

Mississippi

Mississippi State Department of Health

570 East Woodrow Wilson Drive
Jackson, MS 39216

1-800-826-2961 TTY/TTD: 711
http://www.msdh.state.ms.us/msdhsite/index.cfm/4,0,204,html

Missouri

Missouri Dept of Health and Senior Services - Bureau of HIV, STD, and Hepatitis

P.O. Box 570
Jefferson City, MO 65102-0570

1-573-751-6439 TTY/TTD: 711
Email: info@health.mo.gov
http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php

Montana

Montana AIDS Drug Assistance Program

P.O. Box 202951
Cogswell Bldg C-211
Helena, MT 59620-9910

1-406-444-3565 TTY/TTD: 711
http://dphhs.mt.gov/publichealth/hivstd/treatmentprogram.aspx

Nebraska

Nebraska Department of Health & Human Services - AIDS Drug Assistance Program

301 Centennial Mall South
Lincoln, NE 68509

1-402-559-4673 TTY/TTD: 711
Email: DHHS.Helpline@nebraska.gov
http://dhhs.ne.gov/

Nevada

Nevada DPBH, HIV/AIDS Division

4150 Technology Way
Carson City, NV 89706-2009

1-775-684-4247 TTY/TTD: 711
Fax: 1-775-684-4056
http://health.nv.gov/HIVCarePrevention.htm

New Hampshire

Department of Health and Human Services - Ryan White CARE Program

129 Pleasant Street
Concord, NH 03301-3852

1-603-271-4502 TTY/TTD: 711
http://www.dhhs.nh.gov/dphs/bchs/std/care.htm

New Jersey

New Jersey Department of Health

Division of HIV, STD, and TB Services

P.O. Box 364
Trenton, NJ 08625-0363

1-800-624-2377 TTY/TTD: 711
Fax: 1-609-633-2494
http://www.state.nj.us/health/aids/contact.shtml

New Mexico

New Mexico Department of Health

1190 St. Francis Dr
Suite S1200
Santa Fe, NM 87502

1-505-827-2435 TTY/TTD: 711
http://nmhivguide.org/search_detail.php?id=75

SECTION 7 AIDS Drug Assistance Program (ADAP) (con't)

New York

HIV Uninsured Care Program

Empire Station
P.O. Box 2052
Albany, NY 12220-0052

1-800-542-2437 TTY/TTD: 1-518-459-0121
Email: ADAP@health.state.ny.us
http://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm

North Carolina

Communicable Disease Branch, Div of Public Health

1902 Mail Service Center
Raleigh, NC 27699-1902

1-877-466-2232 TTY/TTD: 711
http://epi.publichealth.nc.gov/cd/hiv/adap.html

North Dakota

ND Dept Of Health HIV/AIDS Program

2635 East Main Avenue
Bismarck, ND 58506-5520

1-800-472-2180 TTY/TTD: 711
Fax: 1-701-328-0356
http://www.ndhealth.gov/HIV/

Ohio

Ohio HIV Drug Assistance Program

246 N. High Street
Columbus, OH 43215

1-800-777-4775 TTY/TTD: 711
http://www.odh.ohio.gov/odhprograms/hastpac/hivcare/OHDAP/drgasst1.aspx

Oklahoma

AIDS Drug Assistance Program

1000 NE Tenth St
Oklahoma City, OK 73117-1299

1-405-271-4636 TTY/TTD: 711
http://www.ok.gov/health/Disease,_Prevention,_Preparedness/HIV_STD_Service/Ryan_White_Programs/

Oregon

CAREAssist - Ryan White ADAP Program

P.O. Box 14450
Portland, OR 97293-0450

1-800-805-2313 TTY/TTD: 711
Fax: 1-971-673-0177
Email: care.assist@state.or.us
http://public.health.oregon.gov/PHD/Directory/Pages/program.aspx?pid=111

Pennsylvania

Division of HIV/AIDS

Prevention, Care and Special Pharmaceutical Benefits Program

625 Forster Street
Harrisburg, PA 17120

1-717-783-0572 TTY/TTD: 711
http://www.portal.state.pa.us/portal/server.pt/community/department_of_health_information/10674/contact_us/559346

Rhode Island

Ryan White AIDS Drug Assistance Program (ADAP)

57 Howard Avenue
Cranston, RI 02920

1-401-462-3295 TTY/TTD: 711
www.health.ri.gov

SECTION 7 AIDS Drug Assistance Program (ADAP) (con't)

South Carolina

South Carolina AIDS Drug Assistance Program

2600 Bull Street
Columbia, SC 29201
1-800-856-9954 TTY/TTD: 711
Email: info@dhec.sc.gov
http://www.dhec.sc.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/

South Dakota

Ryan White Part B Care Program

615 E. 4th Street
Pierre, SD 57501
1-800-592-1861 TTY/TTD: 711
Email: DOH.INFO@state.sd.us
http://doh.sd.gov/diseases/infectious/ryanwhite/

Tennessee

Tennessee HIV Drug Assistance Program (HDAP)

710 James Robertson Parkway
Nashville, TN 37243
1-615-741-3111 TTY/TTD: 711
Email: tn.health@tn.gov
http://tn.gov/health

Texas

Texas Department of State Health Services

P.O. Box 149347
MC 1873
Austin, TX 78714
1-512-533-3000 TTY/TTD: 711
Fax: 1-512-533-3178
Email: feedback.hivmeds@dshs.state.tx.us
http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34561&id=5415&terms=SPAP

Utah

Bureau Of Epidemioloy

288 North 1460 West
Box 142104
Salt Lake City, UT 84114-2104
1-801-538-6197 TTY/TTD: 711
http://health.utah.gov/epi/treatment/

Vermont

Vermont Department of Health - Vermont Medical Assistance Program (VMAP)

108 Cherry Street
Burlington, VT 05402
1-800-464-4343 TTY/TTD: 711
Fax: 1-802-865-7754
http://healthvermont.gov

Virginia

Virginia AIDS Drug Assistance Program (ADAP)

109 Governor Street
Richmond, VA 23219
1-855-362-0658 TTY/TTD: 711
Fax: 1-804-864-8139
Email: VDH_EPI_comments@vdh.virginia.gov
http://www.vdh.virginia.gov/epidemiology/

Washington

Washington State Department of Health - Early Intervention Program (EIP)

P.O. Box 47890
Olympia, WA 98504
1-877-376-9316 TTY/TTD: 711
Fax: 1-360-664-2216
Email: ask.EIP@doh.wa.gov
http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP.aspx

SECTION 7 AIDS Drug Assistance Program (ADAP) (con't)

West Virginia

AIDS Drug Assistance Program

350 Capitol Street
Room 125
Charleston, WV 25301

1-800-642-8244 TTY/TTD: 711
http://www.dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx

Wisconsin

Department of Health Services

1 West Wilson Street
Madison, WI 53703

1-800-991-5532 TTY/TTD: 1-888-701-1251
http://www.dhs.wisconsin.gov/aids-hiv/Resources/Overviews/AIDS_HIV_drug_reim.htm

Wyoming

Wyoming Department of Health

401 Hathaway Building
Cheyenne, WY 82002

1-866-571-0944 TTY/TTD: 711
http://health.wyo.gov/main/about.html

For questions regarding your coverage, please contact Customer Service:

Monday through Friday,
from 8 a.m. to 9 p.m. ET, at 1-866-470-6265
TTY: 711

Anthem Blue Cross
P.O. Box 110
Fond du Lac, WI 54936-0110

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4010 Truxel Road
Sacramento, CA 95834-3725

1-800-655-6397

www.porac.org/insurance-and-benefits/

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