Evidence of Coverage

Effective January 1, 2023

Blue Cross MedicareRx (PDP) with Senior Rx Plus plan

Prescription Drug Plan (PDP)

Anthem

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

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

CalPERS

EVIDENCE OF COVERAGE

January 1, 2023 – December 31, 2023

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

This document gives you the details about your Medicare prescription drug coverage and non-Medicare supplemental drug coverage from January 1, 2023 – December 31, 2023. **This is an important legal document. Please keep it in a safe place**.

For pharmacy-related benefits questions, please call Pharmacy Member Services at **1-833-285-4636**, or for TTY users, **711**, 24 hours a day, 7 days a week.

For all other questions, please call Member Services 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**.

Important: This is not an insured benefit plan. Anthem Blue Cross has been retained to administer certain parts of this Plan. The Medicare benefits described in this *Evidence of Coverage* are being provided pursuant to the contract between Anthem Blue Cross and the Centers for Medicare & Medicaid Services. Anthem Blue Cross provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

This document may be available in alternate formats. Please call the Member Services number listed above for additional information.

The formulary and pharmacy network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your cost sharing;
- Your prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

OMB Approval 0938-1051 (Expires: February 29, 2024)

YOUR BENEFITS CHART

Your 2023 Prescription Drug Benefits Chart
Formulary P3, 10/25/45 (with Senior Rx Plus)
Insurance and Benefits Health Plan of Peace Officers Research Association of California

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	P3
Deductible	$100
Supplemental Gap Coverage	Not Applicable
Covered Services	What you pay
Part D Initial Coverage	

Below is your payment responsibility from the time you meet your deductible, until the amount paid by you and the Coverage Gap Discount Program for covered Part D prescriptions reaches your True Out of Pocket limit of $7,400.

Retail Pharmacy	per 30-day supply
• Select Generics	$0 copay Deductible waived on Select Generics
• Generics	$10 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$45 copay

Covered Services	What you pay
Retail Pharmacy	per 90-day supply
• Select Generics	$0 copay Deductible waived on Select Generics
• Generics	$30 copay
• Preferred Brands	$75 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$135 copay

Many of our retail pharmacies can dispense more than a 30-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.

Covered Services	What you pay
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 Drugs, including Specialty Drugs and Non-Formulary Drugs	$75 copay

Covered Services	What you pay
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 $7,400.	
Retail and Mail-Order Pharmacies	Up to a 90-day supply
• Select Generics	$0 copay
• Generics	5% coinsurance with a minimum of $4.15 and a maximum of $10
• Brand-Name Drugs	5% coinsurance with a minimum of $10.35 and a maximum of $25

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare 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 drug coverage unless you fall into a high risk category, then it is covered under medical coverage. Other common vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to pay its share of the cost. Please see your *Evidence of Coverage* for complete details on what you pay for vaccines.

- **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 benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Your 2023 Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
These are prescription drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These prescription drugs are covered by your Senior Rx Plus benefits. Some of these drugs may be required on your retiree drug plan by state regulations. These drugs do not count towards your deductible or True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.	
Retail Pharmacy	per 30-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$10 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs	$45 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$10 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs	$45 copay
Other Non-Part D Coverage	Copay or coinsurance
• Non-Part D Diabetic Supplies – Lancets, Blood Sugar Diagnostics and Calibration Solutions	$25 copay
• Non-Part D Diabetic Supplies - Glucometers	$25 copay per Covered Device
• Contraceptive Devices	Limit 1 per year; 33% coinsurance per Covered Device

Covered Services	What you pay
Mail-Order Pharmacy	per 90-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$20 copay
• Preferred Brands	$40 copay
• Non-Preferred Drugs	$75 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$20 copay
• Preferred Brands	$40 copay
• Non-Preferred Drugs	$75 copay
Other Non-Part D Coverage	Copay or coinsurance
• Non-Part D Diabetic Supplies – Lancets, Blood Sugar Diagnostics and Calibration Solutions	$40 copay
• Non-Part D Diabetic Supplies - Glucometers	$25 copay per Covered Device
• Contraceptive Devices	Limit 1 per year; 33% coinsurance per Covered Device

- **Over the Counter Drugs:** To get over the counter drugs listed as covered under your drug plan, you must have a prescription from your provider and have the prescribed drug filled by the pharmacist.

CHAPTER 1:

Getting started as a member

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

Important: This is not an insured benefit plan. Anthem Blue Cross has been retained to administer certain parts of this plan. The Medicare benefits described in this *Evidence of Coverage* are being provided pursuant to the contract between Anthem Blue Cross and the Centers for Medicare & Medicaid Services. Anthem Blue Cross provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

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* document about?

This *Evidence of Coverage* document explains how to get your prescription drugs. It explains your rights and responsibilities, what is covered, and what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

This document explains benefits you have under your Medicare prescription drug coverage (also referred to as Group Part D) and your non-Medicare supplemental drug coverage. We will refer to your complete drug coverage as your “retiree drug coverage” or “your plan.” Your retiree drug coverage includes basic coverage provided by Group Part D and supplemental coverage provided by Senior Rx Plus.

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* document.

If you are confused, concerned or just have a question, please contact Pharmacy Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

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, 2023, or on your group-sponsored plan's renewal date. We can also choose to stop offering the plan in your service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue each year 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 have Medicare Part A or Medicare Part B (or you have both Part A and Part B).
- - *and* - you are a United States citizen or are lawfully present in the United States.
- - *and* - 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, and you have Medicare Part A or Medicare Part B (or you have both Part A and Part B). Section 2.2 explains Medicare Part A and Medicare Part B. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- - *and* - you are eligible for coverage under your group-sponsored health plan retiree benefits.

If you have questions regarding your eligibility for coverage under your group-sponsored retiree benefits, please contact the group sponsor.

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, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the service area for our plan

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, 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, you cannot remain a member of this plan. Please contact all of the following to update your contact information:

- Member Services.
- Group sponsor of your group plan.
- Social Security. You can find their phone numbers and contact information in Chapter 2, Section 5.

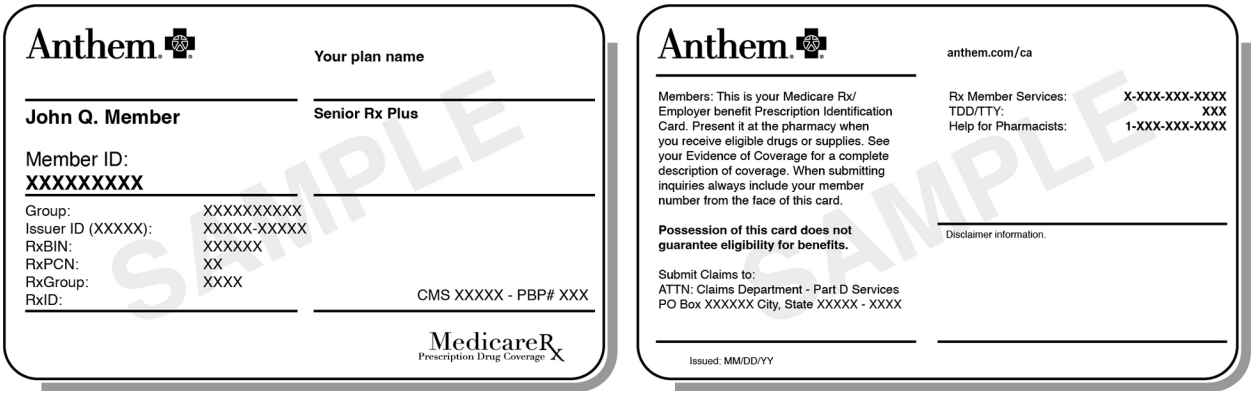
Section 2.4 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Cross MedicareRx (PDP) with Senior Rx Plus if you are not eligible to remain a member on this basis. Blue Cross MedicareRx (PDP) with Senior Rx Plus must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



Please carry your plan membership card with you at all times and remember to show it when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

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 *Pharmacy Directory*

The *Pharmacy Directory* lists our network pharmacies. Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 3, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

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

If you don't have the *Pharmacy Directory*, you can get a copy from Pharmacy Member Services. You can also find this information on **www.anthem.com/ca**.

Section 3.3 The 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 explains which Part D prescription drugs are covered under the Part D benefit included in 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 explains if there are any rules that restrict coverage for your drugs.

We'll provide you a copy of the *Drug List*. To get the most complete and current information about which drugs are covered, you can visit the plan's website at **www.anthem.com/ca**, or you can call Pharmacy Member Services.

SECTION 4 Your monthly costs

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

In some situations, your plan premium could be <u>less</u>

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2 explains 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 explains your drug coverage. If you don't have this insert, please call Member Services and ask for the "*LIS Rider*." Phone numbers for Member Services are printed on the back cover of this document. 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 sponsor's bill on your behalf. If your group sponsor 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 sponsor must apply the subsidy toward the amount you contribute to this plan.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs." If you need a copy you can download it 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 4.1 Plan premium

Your coverage is provided through a contract with your group sponsor. Please contact your group sponsor to get information on any plan premium amounts for which you may be responsible. Or, if you are billed directly by your plan, please contact Member Services.

Section 4.2 Monthly Medicare Part B premium

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.

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs." If you need a copy you can download it 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 4.3 Part D "Late Enrollment Penalty"

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage, or there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription 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 cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage.

You will have to pay this penalty for as long as you have Part D coverage.

Your Part D late enrollment penalty is considered part of your plan premium. When you first enroll in your plan, we let you know the amount of the penalty. The Part D late enrollment penalty is added to the monthly premium charged to your group for your coverage. If you think you may have a late enrollment penalty, you should contact your group sponsor 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. If you do not pay your Part D late enrollment penalty, you could be disenrolled from the plan.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or 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.
    - **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
    - **Note:** The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not 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 2022, this average premium amount was $33.37. This amount may change for 2023.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $33.37, which equals $4.67. This rounds to $4.70. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

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

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- 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, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D 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 disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit **https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans**.

Part D-IRMAA is assessed to all Medicare beneficiaries with Part D coverage whose incomes exceed the federal government established threshold amounts. 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 sponsor.

Please carefully review all communications you receive from Medicare. As a Part D group sponsor, we are not billing or collecting the Part D-IRMAA; however, as a group 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. 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.**

If you disagree about paying an extra amount, 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 4.5 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 premium 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 with your prescription drug costs, the "Extra Help" program will pay part of your monthly plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover. 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.

If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

SECTION 5 Keeping your plan membership record up to date

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 the 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 a group sponsor)
- 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 Member Services. Please remember to also notify your 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.

SECTION 6 How other insurance works with our plan

Other insurance

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 our plan. This is called **Coordination of Benefits**.

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 Member Services. 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.

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. Your retiree drug coverage includes basic coverage provided by Group Part D benefits and additional coverage provided by your Senior Rx Plus supplemental benefits. If you have other insurance, tell your doctor, hospital, and pharmacy.

Your Group Part D and Senior Rx Plus coverage always work together so that you pay the copayment or coinsurance shown in the benefits chart located at the front of this document 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 ("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/domestic partner 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.

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Your plan contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance, please call or write to Member Services. We will be happy to help you.

Method	Pharmacy Member Services – Contact Information
CALL	For questions related to pharmacy benefits, please call us at **1-833-285-4636**. Calls to this number are free. 24 hours a day, 7 days a week Member Services 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	CarelonRx ATTN: Claims Department - Part D Services P.O. Box 52077 Phoenix, AZ 85072-2077

Method	Member Services – Contact Information
CALL	For all other questions, please call Member Services at **1-866-470-6265** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays Member Services 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.
FAX	**1-855-358-1226**

Method	Member Services – Contact Information
WRITE	Blue Cross MedicareRx (PDP) with Senior Rx Plus P.O. Box 173144 Denver, CO 80217-3144
WEBSITE	**www.anthem.com/ca**

How to contact us when you are asking for a coverage decision or appeal 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. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals 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 or 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 and Appeals – Contact Information
CALL	**1-833-285-4636** Calls to this number are free. 24 hours a day, 7 days a week Member Services 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	Anthem Blue Cross 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. 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	**1-833-285-4636** Calls to this number are free. 24 hours a day, 7 days a week Member Services 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	Anthem Blue Cross 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. If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask your plan for reimbursement or to pay the provider bill, 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	**1-833-285-4636** Calls to this number are free. 24 hours a day, 7 days a week Member Services 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	CarelonRx ATTN: Claims Department - Part D Services P.O. Box 52077 Phoenix, AZ 85072-2077

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** 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.

Method	Medicare – Contact Information
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 documents 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 and review the information with you. 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 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. SHIP is an independent program (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 SHIP counselors 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 with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

Method to Access SHIP and Other Resources:

- Visit **www.medicare.gov**
- Click on "**Talk to Someone**" in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click **GO**. This will take you to a page with phone numbers and resources specific to your state.

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

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. QIOs have different names depending on which state they are in.

The QIO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. It is an independent organization. It is not connected with our plan.

You should contact the QIO 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 listing, which is located in the QIO section of Chapter 11 in this document.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents 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. 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 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 a.m. to 7:00 p.m., 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 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	**www.ssa.gov**

SECTION 6 Medicaid

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.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" are:

- **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+).
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

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

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

The Medicare.gov website (**https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/6-ways-to-get-help-with-prescription-costs**) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

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.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify 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 state-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 a process for 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 Member Services if you have questions.

There are programs in Puerto Rico, U.S. Virgin Islands, 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.

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

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP) within our service area, or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. The 70% 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 on the ADAP formulary 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/underinsured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP.

State Pharmaceutical Assistance Programs (SPAP)

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, please refer to the state-specific agency listing, which is located in the SPAP section of Chapter 11 in this document.

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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information, 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	**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, 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 users should call **1-877-486-2048** with questions related to your Medicare coverage under this plan.

CHAPTER 3:

Using the plan for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D 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 2023* handbook. Your Part D prescription drugs are covered under our plan.

Section 1.1 Basic rules for the 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 you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (see Section 2, "Fill your prescriptions at a network pharmacy or through your plan's mail-order service").
- The drug is a Medicare Part D eligible drug. Medicare Part D eligible drugs are all approved by the Food and Drug Administration (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 benefits chart located at the front of this document.
- 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 benefits chart located at the front of this document will have a section called "Extra Covered Drugs." You can find out which specific drugs are covered by checking your *Extra Covered Drug List.* To get coverage for these additional drugs, you must have a prescription from your provider and have the prescription filled by the pharmacist.
- 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 may not have coverage for it. If your provider feels you should use the new drug, you or your provider 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 FDA 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 the plan's mail-order service

Section 2.1 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. It also means "Extra Covered Drugs" if shown in the benefits chart located at the front of this document.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory* by visiting our website, **www.anthem.com/ca**. You can also call Pharmacy Member Services.

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 Pharmacy Member Services. You can also use the *Pharmacy Directory*. You can also find this information on **www.anthem.com/ca**.

What if you need a specialized pharmacy?

Some 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, an LTC facility, such as a nursing home, has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Pharmacy Member Services.
- 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 Pharmacy Member Services.

Section 2.3 Using the plan's mail-order service

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 benefits chart located at the front of this document to verify the maximum day supply limits in your plan for mail-order drugs. Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs may not be available at the mail-order cost share.

To get order forms and information about filling your prescriptions by mail, please call the Pharmacy Member Services number on the back cover of this *Evidence of Coverage* or on the back of your plan membership card. 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.

Automatic mail-order delivery is available for new and refill prescriptions

If you sign up for our automatic mail-order delivery service, the pharmacy will automatically fill and deliver your prescriptions. This service is optional and you may opt out at any time by calling Pharmacy Member Services.

- New prescriptions received from health care providers will be filled and delivered automatically, without checking with you first, if you used mail-order services with this plan in the past. If you do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Pharmacy Member Services.

  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.
- For refills of your drugs, the automatic mail-order delivery service will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. 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 choose not to use our auto refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 30 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.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

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.

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 long-term supply of maintenance drugs. If you get a long-term supply of maintenance drugs at a retail network pharmacy, your cost sharing may be different than it is for a long-term supply from the mail-order service. Please check the benefits chart located at the front of this document to find out what your costs will be if you get a long-term supply of maintenance drugs from a retail pharmacy. Your *Pharmacy Directory* explains which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Pharmacy Member Services for more information.

You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the 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.

Please check first with Pharmacy Member Services to see if there is a network pharmacy nearby. You will most likely 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.

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.

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 cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Chapter 5, Section 2 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 benefits chart located at the front of this document, 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 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 meets Medicare's requirements and has been approved by Medicare.

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 for the diagnosis or condition for which it is being prescribed.
- - *or* - Supported by certain references such as the *American Hospital Formulary Service Drug Information* and the *DRUGDEX Information System*.

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. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products.

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. These drugs will be identified on our Prior Authorization document. You can request this document by calling Pharmacy Member Services or you can visit the plan's website **www.anthem.com/ca**.

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 copay when you fill a covered brand drug at a network pharmacy.

The *Drug List* may include brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name and owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biologial products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

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 the *Drug List*. In some cases, you may be able to obtain a drug that is not on the *Drug List*. For more information, please see Chapter 7, to learn how to request an exception for a drug.

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

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 benefits chart located at the front of this document. Generic drugs are usually low cost so they are covered in a lower tier; however, some more expensive drugs may be on a higher tier.

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 benefits chart located at the front of this document.

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. Visit the plan's website at **www.anthem.com/ca**. The *Drug List* on the website is always the most current.
2. Call Pharmacy Member Services to find out if a particular drug is on your plan's *Drug List* or to ask for a copy of the list.

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 encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the *Drug List*.

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

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. Contact Pharmacy Member Services 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).

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

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 instead of the brand name drug**. 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**." This is put in place to ensure medication safety and help 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 usually 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 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 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

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our *Drug List* or is on our *Drug List* 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.
- 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.

- There are things you can do if your drug is not covered in the way that you'd like it to be covered. 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 options:

- You may be able to get a temporary supply of the drug.
- 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 must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking must no longer be on the plan's *Drug List* OR is now restricted in some way.

- If you are a new member, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- If you were in the plan last year, we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of one-month's supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of one-month's supply of medication. The prescription must be filled at a network pharmacy. Please note: A 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 facility and need a supply right away:**

  We will cover one 31-day emergency supply of a particular drug, or less, if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Pharmacy Member Services.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by your plan that might work just as well for you. You can call Pharmacy Member Services 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.

2) You can ask for an exception

You and your provider can ask us to make an exception and cover the drug in the way you would like it 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. 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 the plan 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 explains 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, talk to your provider. There may be a different drug in a lower cost sharing tier that might work just as well for you. You can call Pharmacy Member Services 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.

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 explains 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 can make some changes to your *Drug List*. You will receive notice when necessary. For example, your plan might:

- **Add or remove drugs from the *Drug List*.**
- **Move a drug to a higher or lower cost sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic drug**.

We must follow Medicare requirements before we change your plan's *Drug List*.

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

Information on changes to drug coverage

If changes to the *Drug List* occur, you will get direct notice when changes are made to a drug that you are taking. Notice may be sent after the change has been made.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the *Drug List* (or we change the cost sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our *Drug List* if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our *Drug List*, but immediately move it to a higher cost sharing tier or add new restrictions or both when the generic drug is added.
    - We may not tell you in advance before we make that change – even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
    - You or your prescriber 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.
- **Unsafe drugs and other drugs on the *Drug List* that are withdrawn from the market**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the *Drug List*. If you are taking that drug, we will tell you right away.
    - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Drugs that are no longer considered Part D eligible**
    - If CMS changes the Part D status of a drug, CMS will notify us that the drug is no longer deemed eligible for coverage under your Part D plan.
    - If this happens, we will immediately remove the drug from the Part D *Drug List*.
- **Other changes to drugs on the *Drug List***
    - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the *Drug List*, or change the cost sharing tier, or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a one-month's supply of the drug you are taking at a network pharmacy.

- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 7.

Changes to the *Drug List* that do not affect you during this plan year

We may make certain changes to the *Drug List* that are not described above. In these cases, the change will not apply to you if you are taking the drug, when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the *Drug List*.

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, a Part D status change or other change noted in the sections above), 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.

We will not tell you about these types of changes directly during the current plan year. You will need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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

Section 7.1 Types of drugs we do not cover

This section explains 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 benefits chart. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. For information about appealing a decision, go to Chapter 7.

Here are a few 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 or 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 references, such as the *American Hospital Formulary Service Drug Information* and the *DRUGDEX Information System.*
- Your plan does not cover drugs not listed in your *Part D Formulary* or *Extra Covered Drug List*, including when these drugs are ingredients in a compound drug.

In addition, by law, the following 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 benefits chart located at the front of this document 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 used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs 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 benefits chart located at the front of this document, the amount you pay for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this document.

In addition, if you are **receiving "Extra Help"** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. 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 Filling a prescription

Section 8.1 Provide your plan membership information

To fill your prescription, provide your plan membership information which can be found on your plan membership card, at the network pharmacy you choose. The network pharmacy will automatically bill your plan for *our* share of your 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 plan membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can 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 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 your plan?

If you are **admitted to a hospital or to a skilled nursing facility** for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, your plan will cover your prescription drugs as long as the drugs meet all rules for coverage described in this chapter.

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 LTC facility, you may get your prescription drugs through the facility's pharmacy or the one that it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Pharmacy Member Services. 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.

What if you're a resident in a LTC facility and need a drug that is not on our *Drug List* or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

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 explains 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?

If you currently have other prescription drug coverage through your retiree group please contact **that group's sponsor**. They can help you determine how your current prescription drug coverage will work with your plan.

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication, or anti-anxiety drugs) that are 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 these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We may conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We may do a review, each time you fill a prescription or 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 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 for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids, and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid medications from a certain doctor(s)
- Limiting the amount of opioid medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 7 for information about how to ask for an appeal.

You will not be placed on our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 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. One program is called a Medication Therapy Management (MTM) program. These programs are voluntary and free. A team of pharmacists and doctors developed the programs for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely 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. During the review, you can talk about 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 which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists and other health care providers. Also, keep your medication list up to date and 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. If you have any questions about these programs, please contact Member Services.

CHAPTER 4:

What you pay for your Part D prescription drugs

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 explains your drug coverage. If you don't have this letter, please call Member Services and ask for the *"LIS Rider."* Phone numbers for Member Services are printed on the back cover of this document.

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 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 benefits chart located at the front of this document will have a section called "Extra Covered Drugs."

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3, Sections 1 through 4 explain these:

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

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called "cost sharing." The following represents the 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 percentage of the total cost of the drug you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does not count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

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

Your out-of-pocket costs 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):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage (if your plan has one)

    - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our 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, by a State Pharmaceutical Assistance Program (if available in your state) that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent the total of the amount of the TrOOP listed in your benefit chart in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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

Your out-of-pocket costs do not include any of these types of payments:

- Your monthly premium, if applicable.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our "Extra Covered Drugs," additional coverage benefits, but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- 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 such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Services.

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

- We will help you. The Part D EOB report you receive includes the current amount of your out-of-pocket costs. When this amount reaches the TrOOP amount shown in your benefit chart, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- 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 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?

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 benefits chart located at the front of this document. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage, if applicable, as shown in your benefit chart

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

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 summary 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.

If you have had one or more prescriptions filled through your plan during the previous month we will send you a *Part D Explanation of Benefits* ("*Part D EOB*"). The *Part D EOB* 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 copay 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 the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions**. This will include information about other available drugs with lower cost sharing for each prescription claim.

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 plan membership card every time you get a prescription filled**. This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, 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, give us copies of these receipts.

  Here are examples of when you should give us copies of your drug receipts:

  - 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.
  - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.
- **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. 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. 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 EOB*", look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call Member Services. Be sure to keep these reports.

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

If your plan has a deductible, once you have paid the deductible amount for your drugs, you move on to 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 benefits chart located at the front of this document.

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 network retail pharmacy
- A pharmacy that is not in your plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- Your plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 and your plan's *Pharmacy Directory*. You may also contact Member Services.

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 (TrOOP) amount, your plan's Initial Coverage Stage continues until you reach your TrOOP amount. The benefits chart located at the front of this document will not show an Initial Coverage Limit amount. It will only show the TrOOP amount.

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

If 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. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. 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.

SECTION 6 Costs in the Coverage Gap Stage

If your copay or coinsurance amount does not change until you reach your True Out-of-Pocket (TrOOP) amount, the benefits chart located at the front of this document will not have a "Part D Gap Coverage" section.

If your copay or coinsurance amount does change once you reach the $4,660 Initial Coverage Limit, the benefits chart located at the front of this document will include a "Part D 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 program or the Program of All-Inclusive Care for the Elderly (PACE), 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 2023, once the cost paid by you and this plan

reaches $4,660, 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) reaches $7,400.

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 benefits chart located at the front of this document. The "Extra Covered Drugs" benefit, if included, is provided by your Senior Rx Plus coverage. Once your TrOOP costs reach the amount shown on the benefits chart located at the front of this document, you will move onto the Catastrophic Coverage Stage.

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

You enter 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 benefits chart located at the front of this document.

SECTION 8 Additional benefits information

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 (TrOOP) limit. If your plan includes coverage for additional drugs, the benefits chart located at the front of this document will have a section called "Extra Covered Drugs." You can find out which specific drugs are covered by checking your *Extra Covered Drug List.* To get coverage for these additional drugs, you must have a prescription from your provider and have the prescription filled by the pharmacist.

SECTION 9 Part D Vaccines. What you pay for depends on how and where you get them

Your plan provides coverage for a number of Part D vaccines. Because coverage for vaccines can be complicated, we suggest that you call Member Services prior to receiving any vaccinations if you have any concerns.

There are two parts to your coverage of vaccinations:

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

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

2. **Where you get the vaccine.**
    - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
    - A pharmacist may give the vaccine in the pharmacy or another provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask your plan to pay you back for our share of the cost.
- Other times, when you get the vaccination, you will pay only your share of the cost under your Part D benefit.

Below are three examples of ways you might get a Part D vaccine. Remember, 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 get your vaccination at the network pharmacy. Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.

- You will pay the pharmacy your coinsurance or copayment for the vaccine itself which includes 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 the cost for the provider to give it to you.
- You can then ask your plan to pay its share of the cost by using the procedures that are described in Chapter 5.
- 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. You may not be reimbursed the entire amount you paid because the doctor's office may be considered out-of-network under your Part D plan. If you get "Extra Help," we will reimburse you for this difference.

Situation 3:

You buy the Part D vaccine itself 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 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.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. You may not be reimbursed the entire amount you paid because the doctor's office may be considered out-of-network under your Part D plan. 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:

CarelonRx
ATTN: Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

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 your plan. For more information, please contact Member Services.

CHAPTER 5:

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

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

Sometimes when you get a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan or you may receive a bill from a provider. In these cases, you can ask your plan to pay you back. Paying you back is often called "reimbursing" you. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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 Section 2.

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, 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.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out of network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion of these circumstances.

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. This 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 costs. You will need to submit paperwork for us to handle the reimbursement.

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 document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. You must submit your claim to us within one year of the date you received the service, item, or drug.

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 Member Services and ask for the form.

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

CarelonRx
ATTN: Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

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, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. 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. We will send you a letter explaining the reasons why we are not sending the payment 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 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. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, or alternate formats)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Your plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in alternate formats at no cost if you need it. We are required to give you information about your plan's benefits in a format that is accessible and appropriate for you.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from your plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services. You may also file a complaint with **Medicare** by calling **1-800-MEDICARE** (**1-800-633-4227**) or directly with the Office for Civil Rights **1-800-368-1019** or TTY **1-800-537-7697**.

Section 1.2 We must ensure that you get timely access to your covered drugs

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 explains what you can do.

Section 1.3 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.

- You have rights related to your 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 explains 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.
- Except for the circumstances noted below, if we intend to 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 or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - 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; typically, this requires that information that uniquely identifies you not be shared.

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 Member Services.

Below is the Notice of Privacy Practices as of May 2018. This Notice can change so to make sure you're viewing the most recent version, you can request the current version from Member Services. Phone numbers are printed on the back cover of this document, or view it on our website at **www.anthem.com/ca/privacy**.

Protecting your personal health information is important. Every year, we're required to send you specific information about your rights and some of our duties to help keep your information safe. This notice combines two of these required yearly communications:

- State Notice of Privacy Practices
- Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

State Notice of Privacy Practices

When it comes to handling your health information, we follow relevant state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice:

- Explains your rights and our duties under state law.

- Applies to health, dental, vision and life insurance benefits you may have.

Your state may give you additional rights to limit sharing your health information. Please call the Member Services phone number on your plan membership card for more details.

Your personal information

Your non-public (private) personal information (PI) identifies you and it's often gathered in an insurance matter. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may receive your PI from others, such as doctors, hospitals or other insurance companies. We may also share your PI with others outside our company – without your approval, in some cases. But we take reasonable measures to protect your information. If an activity requires us to give you a chance to opt out, we'll let you know and we'll let you know how to tell us you don't want your PI used or shared for an activity you can opt out of.

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.

HIPAA Notice of Privacy Practices

We keep the health and financial information of our current and former members private as required by law, accreditation standards and our own internal rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

Your Protected Health Information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

Payment: We collect, use and share PHI to take care of your account and benefits, or to pay claims for health care you get through your plan.

Health care operations: We collect, use and share PHI for our health care operations.

Treatment activities: We don't provide treatment, but we collect, use and share information about your treatment to offer services that may help you, including sharing information with others providing you treatment.

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.

- We may collect and use publicly and/or commercially available data about you to support you and help you get health plan benefits and services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations visit **www.anthem.com/ca/privacy** for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you 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 plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests. You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we contact you.

Sharing your PHI with others: In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time.

You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

Other reasons we may use or share your information:

We are allowed, and in some cases required, to share your information in other ways – usually for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medicines
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.

- Addressing workers' compensation, law enforcement and other government requests, and to alert proper authorities if we believe you may be a victim of abuse or other crimes.
- Responding to lawsuits and legal actions.

If you're enrolled with us through an employer, we may share your PHI with your group health plan. If the employer pays your premium or part of it, but doesn't pay your health insurance claims, your employer can only have your PHI for permitted reasons and is required by law to protect it.

Authorization: We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use your genetic information to decide whether we'll give you coverage or decide the price of that coverage.

Race, ethnicity, language, sexual orientation and gender identity: We may receive race, ethnicity, language, sexual orientation and gender identity information about you and protect this information as described in this notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't use race, ethnicity, language, sexual orientation and gender identity information to decide whether we'll give you coverage, what kind of coverage and the price of that coverage. We don't share this information with unauthorized persons.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by unencrypted email before sending it to you. We will provide you a copy of your PHI usually within 30 days of your request. If we need more time, we will let you know.
- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI. We will provide you a list usually within 60 days of your request. If we need more time, we will let you know.
- Ask for 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 sharing of that PHI for treatment, payment or

operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see "Your rights" above). If a law requires sharing your information, we don't have to agree to your restriction.

- Call Member Services at the phone number on your plan membership card to use any of these rights. A representative 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.

How we protect information

We're dedicated to protecting your PHI, and we've set up a number of policies and practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures 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 jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

Potential impact of other applicable laws

HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA.

To see more information

To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy web page at **www.anthem.com/ca/privacy**.

Calling or texting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, just let the caller know or call **1-844-203-3796** to add your phone number to our Do Not Call list. We will then no longer call or text you.

Complaints

If you think we haven't protected your privacy, you can file a complaint with us at the Member Services phone number on your plan membership card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. We will not take action against you for filing a complaint.

Contact information

You may call us at the Member Services phone number on your plan membership card. Our 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. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. 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're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. This Notice was most recently revised in June 2022. This Notice can change so make sure you're viewing the most recent version. You can request the current version from Member Services at the phone number printed on your plan membership card or view it on our website at **www.anthem.com/ca/privacy**.

FOR MAINE RESIDENTS: Maine Notice of Additional Privacy Rights

The Maine Insurance Information and Privacy Protection Act provides consumers in Maine with the following additional rights.

The right:

- To obtain access to the consumer's recorded personal information in the possession or control of a regulated insurance entity
- To request correction if the consumer believes the information to be inaccurate
- To add a rebuttal statement to the file if there is a dispute
- To know the reasons for an adverse underwriting decision (previous adverse underwriting decisions may not be used as the basis for subsequent underwriting decisions unless the carrier makes an independent evaluation of the underlying facts)

And with very narrow exceptions, the right not to be subjected to pretext interviews.

Section 1.4 We must give you information about the 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.

If you want any of the following kinds of information, please call Member Services.

- **Information about your plan.** This includes, for example, information about your plan's financial condition.

- **Information about our network pharmacies.** You have the right to get information about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 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.** You can get an advance directive 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 who can make decisions for you if you can't. You may want to give copies to close friends or family members. 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.**

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

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document explains what you can do.

Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

Section 1.7 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, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019**. TTY users should call **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 **Member Services**.
- You can call **SHIP**. For details, 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 **1-877-486-2048**).

Section 1.8 How to get more information about your rights

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

- You can call **Member Services**.
- You can call **SHIP**. For details, 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 *Medicare Rights & Protections*. The publication is available at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.**
    - Or you can call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

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

Things you need to do as a member of your plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs**. Use this *Evidence of Coverage* document 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 your plan, you are required to tell us**. Chapter 1 tells you about coordinating these benefits.
- **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 get the best care, tell your doctors and other health care providers about your health problems. 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 and get an answer you can understand.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - You must pay your plan premiums, if any, to your group sponsor (or, if you are billed directly, you must send your payment to the address listed on your billing statement).
    - For most of your drugs covered by your plan, you must pay your share of the cost when you get the drug.
    - 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 continue to pay the extra amount directly to the government to remain a member of your plan.

- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan**.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

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 Member Services. 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 problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints**; also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are 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 make things easier, this chapter:

- Uses 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 "organization determination" or "coverage determination" or "at-risk 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. Knowing which terms to use will help you communicate more accurately to 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 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us 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.

Medicare

You can also contact Medicare to get help. To contact 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 also visit the Medicare website (**www.medicare.gov**).

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

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.

Is your problem or concern about your benefits or coverage?

This includes problems about whether prescription drugs are covered or not, the way they are covered, and problems related to payment for prescription drugs.

Yes.

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

No.

Skip ahead to Section 7 at the end of this chapter, "How to make a complaint about quality of care, waiting times, member 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

Coverage decisions and appeals deal with problems related to your benefits and coverage for prescription drugs, including payments. 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 prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. In limited circumstances, a request for a coverage decision will be dismissed, which means we won't review the request. Examples of

when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is a formal process called an appeal. Appeals are discussed in the next section.

Making an appeal

If we make a coverage decision whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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 properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but 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 review organization that is not connected to us. 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

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Member Services**
- **You can get free help from** your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.)
    - 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. If your Level 1 appeal is denied, your doctor or prescriber can request a Level 2 appeal.
- **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.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/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 us a copy of the signed form.

- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** 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

Section 5.1 This section explains 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 include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 3 and 4.

- **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. We also use the term "drug list" instead of "*List of Covered Drugs*" or "*Formulary*."
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover them.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on your plan's *List of Covered Drugs*. **Ask for an exception. Section 5.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 5.2**
- Asking to pay a lower cost sharing amount for a covered drug on a higher cost sharing tier. **Ask for an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**

- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

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

This section explains both how to ask for coverage decisions and how to request an appeal.

Section 5.2 What is an exception?

LEGAL TERMS	Asking for coverage of a drug that is not on the *Drug List* is sometimes called asking for a "**formulary exception**." Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception**." Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a "**tiering 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.

For us to consider your exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you, 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 *Drug List*.**
   - If we agree to cover a drug not on your *Drug List*, you will need to pay the cost sharing amount that applies to all of our drugs *OR* drugs in the non-preferred brand tier. You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 3 describes the extra rules or restrictions that apply to certain drugs on your plan's *Drug List*. If we agree 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 benefits chart located at the front of this document. In general, the lower the cost sharing tier number, the less you will pay as your share of the cost of the drug.
   - If our *Drug List* contains alternative drug(s) for treating your medical condition that are in a lower cost sharing tier than your drug, you can ask us to cover your drug at the cost sharing amount that applies to the alternative drug(s).
     - If the drug you're taking is a brand name drug you can ask us to cover your drug at a lower cost sharing. This would be the lowest tier cost that contains brand name alternatives for treating your condition.
     - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
   - You cannot ask us to change the cost sharing tier for any drug in the Specialty Drug tier.

- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

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. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

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 calendar 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, you can ask for another review by making an appeal.

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

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

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

"**Standard coverage decisions**" are made within **72 hours** after we receive your doctor's statement. "**Fast coverage decisions**" are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a "fast coverage decision." **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received*. (You cannot ask for a fast coverage decision to be paid back for a drug you have already bought.)
- 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 give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "fast coverage decision."

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the "supporting statement,"** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: Your plan considers your request and we give you our answer.

Deadlines for a "fast coverage decision"

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within **24 hours** after we receive your doctor's supporting statement. 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 review organization.
- **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 will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. 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 review organization.

- **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 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 you can 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 review organization.
- **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 you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision made by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.5 Step-by-step: How to make a Level 1 appeal

LEGAL TERMS	An appeal to your plan about a Part D drug coverage decision is called a plan "**redetermination**." A "fast appeal" is also called an "**expedited redetermination**."

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal"

- 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: You, your representative, doctor, or other prescriber must contact your plan and make your Level 1 appeal. If your health requires a quick response, you must ask for a "fast appeal."

- **For standard appeals, submit a written request**. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us**. Chapter 2 has contact information.

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include 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 and your doctor may add more information to support your appeal.

Step 3: 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"

- For fast appeals, 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. Section 5.6 explains the Level 2 appeal 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 you can appeal our decision.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 7 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 we do not give you a decision within 7 calendar days, 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. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested, we must provide the coverage** as quickly as your health requires, but **no later than 7 calendar days** 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 you can appeal our decision.

Deadlines for a "standard appeal" about payment for a drug you have already bought

- 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 review organization.

- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 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 you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

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

LEGAL TERMS The formal name for the "independent review organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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. If, however, we did not complete our review within the applicable timeframe, or made an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- 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 reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for a "fast appeal"

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for a "standard appeal"

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For "fast appeals":

- **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.

For "standard appeals":

- **If the independent review organization says yes to part or all of your** 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 says yes to part or all of your 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 part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). This is called "upholding the decision." It is also called "turning down your appeal." In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. 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.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case 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 you want to go on to Level 3, the details on how to do this are in the written notice you got after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter explains more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

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

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 **An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.**

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **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 can continue to the next level of the review process. The notice you get will tell you what to do for your Level 4 appeal.

Level 4 appeal **The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government.**

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the 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 may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It 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.**

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

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

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

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the member service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Did someone not respect your right to privacy or shared confidential information about you?
Disrespect, poor member service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • 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 Member Services 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	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

LEGAL TERMS	• A "**Complaint**" is also called a "**grievance**." • "**Making a complaint**" is also called "**filing a grievance**." • "**Using the process for complaints**" is also called "**using the process for filing a grievance**." • A "**fast complaint**" is also called an "**expedited grievance**."

Section 7.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step**. If there is anything else you need to do, Member Services will let you know.
- **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 Member Services.
    - 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.
- The deadline for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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.
- **Most complaints are answered within 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 decide to take extra days, we will tell you in writing.

- **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**.
- **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 include our reasons in response to you.

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

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

- **You can make your complaint directly to the Quality Improvement Organization**.
    - 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. Chapter 2 has contact information.

  Or
- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

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**.

You may also call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to 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. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 explains about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your prescription drugs and you will continue to pay your cost share 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 group sponsor.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, 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 1, Section 4.3 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 in our plan during the **Annual Enrollment Period for Individual (non-group) plans**, also known as the "Annual Open Enrollment Period." During this time, review your health and drug coverage and decide on coverage for the upcoming year.

- **The Annual Enrollment Period for Individual (non-group) plans** is from October 15 through December 7.
- **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 *with* a separate Medicare prescription drug plan.
    - Original Medicare *without* a separate Medicare prescription drug plan.
        - If you choose this option, 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 group sponsor.**
- **If you end your group Medicare Part D coverage, your Senior Rx Plus supplemental coverage will end on the same date.**
- **Your membership will end** when your new plan's coverage begins.
- **Note**: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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 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**.

- You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. 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" with paying for your Medicare prescriptions.
    - If we violate our contract with you.
    - If you get 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 Member Services.
    - Chapter 3, Section 10 tells you more about drug management programs.
- **The enrollment time periods vary** depending on your situation.

- **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. You can choose:
    - An Individual (non-group) Medicare prescription drug plan.
    - Original Medicare *without* a separate Medicare prescription drug plan.

      Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

        - **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 group sponsor.**
- **If you end your group Medicare Part D coverage, your Senior Rx Plus supplemental coverage will end on the same date.**
- **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 about ending your membership you can:

- Contact your group sponsor to get information on options available to you.
- Call **Member Services**.
- You can find the information in the ***Medicare & You 2023*** handbook.
- Contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY **1-877-486-2048**).

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

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 the plan in the future. Before ending your group-sponsored Medicare Part D coverage, please contact your group sponsor.

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

If you would like to switch from our plan to:	This is what you should do:
An Individual (non-group) Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. • You will automatically be disenrolled from your group-sponsored plan when your new plan's coverage begins.
An Individual (non-group) Medicare health plan.	• Enroll in the new Medicare health plan between October 15 and December 7. • 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 Member Services. In order to be disenrolled, you must send us a written request. If you need more information on how to do this, call Member Services. 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**.
Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll**. Contact Member Services if you need more information on how to do this. • 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

Until your membership ends, and your new Medicare coverge begins, you must continue to get your prescription drugs through this plan.

- **Continue to use our network pharmacies to get your prescriptions filled**.

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 the plan if any of the following happen:

- If you no longer have 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, call Member Services to find out if the place you are moving or traveling to is in your plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie 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 our plan and that information affects your eligibility for our 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 our 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 plan 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 our 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 sponsor 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 sponsor 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, call Member Services.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

We are not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). (TTY **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 file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* 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. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. 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, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

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. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **www.hhs.gov/ocr/index**.

If you have a disability and need help with access to care, please call us. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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 group 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:

CarelonRx
ATTN: Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

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 benefits chart located at the front of this document.

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 provider. 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 provider 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 Member Services. 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 document explains 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

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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 your plan doesn'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. 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.

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 where 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 (TrOOP) cost for covered drugs during the covered year. You can find this amount listed on the benefits chart at the front of this document.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for prescription drugs after you pay any deductibles.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the member service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

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.

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 Determination – A decision about whether a drug prescribed for you is covered by the 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 isn't

covered under your plan, that isn't a coverage determination. You need to call or write to us to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Non-Medicare prescription drug coverage (for example, from a group sponsor, Tricare or Department of Veterans Affairs) 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.

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.

Deductible – The amount you must pay for prescriptions before our plan pays.

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 our plan.

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, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. 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 your plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our *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 our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Covered Drugs – Is used to describe coverage of drugs which are excluded by law from coverage by Medicare Part D, but 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 benefits chart located at the front of this document. To get coverage for these additional drugs, you must have a prescription from your provider and have the prescription filled by the pharmacist.

Extra Help – A Medicare or a state program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles and coinsurance.

Formulary – See "*List of Covered Drugs (Formulary or Drug List)*."

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 our plan or pharmacies. This does not involve coverage or payment disputes.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. 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've paid and what we have paid on your behalf. To find out if your plan includes an Initial Coverage Limit, refer to the benefits chart located at the front of this document.

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. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-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.

***List of Covered Drugs* (*Formulary or Drug List*)** – A list of prescription drugs covered by your plan.

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. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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).

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 i) HMO, ii) PPO, iii) a Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). 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**.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members 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.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

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, Special Needs 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 our plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances and appeals.

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 pharmacy that contracts with our plan where members of this plan can get their prescription drug benefits. 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 the plan's *Drug List (Formulary)*; therefore, they would not be covered under the 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 benefits chart located at the front of this document.

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 7, 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 such as 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 does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan 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. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. If you would like to know if PACE is available in your state, please contact Member Services.

Part C – See "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress.

Part D 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 after you are first eligible to join a Part D plan.

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. On 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.

Preferred Retail Pharmacy – A network pharmacy that offers covered drugs to members of our 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.

Prior Authorization – Approval in advance to get certain drugs. 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.

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 available online at **www.anthem.com/ca**. Some plans have reduced copayments for Select Generics. If your plan includes a reduced copayment, you can find this information listed on the benefits chart located at the front of this document.

Service Area – A geographic area where you must live to join a particular prescription drug plan. 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 plan 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.

Specialty Drugs – The Centers for Medicare & Medicaid Services (CMS) defines specialty drugs as any drug that costs $830 or more per unit.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

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

SECTION 1 State Health Insurance Assistance Program (SHIP)

The following state agency information was updated on July 11, 2022. For more recent information or other questions, please contact Member Services.

Alabama

Alabama's State Health Insurance Assistance Program
201 Monroe Street, Suite 350,
Montgomery, AL 36104
1-800-243-5463, TTY: **711**
http://www.alabamaageline.gov

Alaska

Alaska State Health Insurance Assistance Program (SHIP)
550 W 7th Ave., Suite 1230
Anchorage, AK 99501
1-800-478-6065, TTY: **1-800-770-8973**
7:00 a.m. to 7:00 p.m.
http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx

Arizona

Arizona State Health Insurance Assistance Program
1789 W. Jefferson Street., #950a
Phoenix, AZ 85007
1-800-432-4040, TTY: **711**
https://des.az.gov/services/older-adults/medicare-assistance

Arkansas

Senior Health Insurance Information Program (SHIIP)
1 Commerce Way 72202
Little Rock, AR 72201
1-800-224-6330, TTY: **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: **1-800-735-2929**
https://www.aging.ca.gov/hicap/

Colorado

Senior Health Insurance Assistance Program (SHIP)
1560 Broadway, Suite 850
Denver, CO 80202
1-888-696-7213, TTY: **1-303-894-7880**
https://cdhs.colorado.gov/contact-cdhs

Connecticut

CHOICES
55 Farmington Ave
Hartford, CT 06105-3730
1-800-203-3447, TTY: **711**
http://www.ct.gov/agingservices

Delaware

Delaware Medicare Assistance Bureau
841 Silver Lake Boulevard
Dover, DE 19904
1-800-336-9500, TTY: **711**
http://www.delawareinsurance.gov/elderinfo/

District of Columbia

Health Insurance Counseling Project (HICP)
500 K Street NE
Washington, DC 20002
1-202-724-5626, TTY: **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: **1-800-955-8770**
http://www.floridashine.org

Georgia

GeorgiaCares
2 Peachtree Street NW, 33rd Floor
Atlanta, GA 30303
1-866-552-4464, TTY: **711**
http://www.mygeorgiacares.org

Hawaii

HAWAII SHIP
250 S Hotel Street, Suite 406
Honolulu, HI 96813-2831
1-888-875-9229, TTY: **1-866-810-4379**
http://www.hawaiiship.org/site/1/home.aspx

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)
700 West State Street., 3rd Floor
Boise, ID 83702-0043
1-800-247-4422, TTY: **711**
https://doi.idaho.gov/shiba/

Illinois

Senior Health Insurance Program (SHIP)
One Natural Resources Way, #100
Springfield, IL 62702-1271
1-800-252-8966, TTY: **1-888-206-1327**
http://www.state.il.us/aging/SHIP/default.htm

Indiana

State Health Insurance Assistance Program (SHIP)
311 W. Washington Street, Suite 300
Indianapolis, IN 46204-2787
1-800-452-4800, TTY: **1-866-846-0139**
http://www.medicare.in.gov

Iowa

Senior Health Insurance Information Program (SHIIP)
1963 Bell Avenue, Suite 100
Des Moines, IA 50315
1-800-351-4664, TTY: **1-800-735-2942**
http://www.shiip.state.ia.us/

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)
503 S. Kansas Ave, New England Bldg
Topeka, KS 66603-3404
1-800-860-5260, TTY: **711**
http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick

Kentucky

State Health Insurance Assistance Program (SHIP)
275 E. Main Street.
Frankfort, KY 40621
1-877-293-7447, TTY: **711**
https://chfs.ky.gov/agencies/dail/Pages/ship.aspx

Louisiana

Senior Health Insurance Information Program (SHIIP)
1702 N. Third Street, P.O. Box 94214
Baton Rouge, LA 70802
1-800-259-5300, TTY: **711**
http://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: **711**
http://www.maine.gov/dhhs/oads/community-support/ship.html

Maryland

Senior Health Insurance Assistance Program (SHIP)
301 W. Preston Street, Suite 1007
Baltimore, MD 21201
1-800-243-3425, TTY: **711**
https://aging.maryland.gov/Pages/state-health-insurance-program.aspx

Massachusetts

Serving Health Information Needs of Elders (SHINE)
1 Ashburton Place, 5th floor
Boston, MA 02108
1-800-243-4636, TTY: **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: **711**
http://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: **1-800-627-3529**
http://www.mnaging.org

Mississippi

MS State Health Insurance Assistance Program (SHIP)
200 South Lamar Street
Jackson, MS 39201
1-800-948-3090, TTY: **711**
http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/

Missouri

CLAIM
1105 Lakeview Avenue
Columbia, MO 65201
1-800-390-3330, TTY: **711**
http://www.missouriclaim.org

Montana

Montana State Health Insurance Assistance Program (SHIP)
111 N. Sanders Street
Helena, MT 59601
1-406-444-4077, TTY: **711**
http://dphhs.mt.gov/SLTC/aging/SHIP

Nebraska

Nebraska Senior Health Insurance Information Program (SHIIP)
1033 O Street, Suite 307
Lincoln, NE 68508
1-800-234-7119, TTY: **711**
http://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: **711**
http://nevadaadrc.com/services-and-programs/medicare/state-health-insurance-assistance-program-ship

New Hampshire

NH SHIP - ServiceLink Resource Center
129 Pleasant Street, Gallen State Office Park
Concord, NH 03301-3857
1-866-634-9412, TTY: **711**
http://www.servicelink.nh.gov/

New Jersey

State Health Insurance Assistance Program (SHIP)
P.O. Box 360
Trenton, NJ 08625-0715
1-800-792-8820, TTY: **711**
http://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: **711**
http://www.nmaging.state.nm.us/

New York

Health Insurance Information Counseling and Assistance Program (HIICAP)
2 Empire State Plaza
Albany, NY 12223-1251
1-800-701-0501, TTY: **711**
https://aging.ny.gov/

North Carolina

Seniors' Health Insurance Information Program (SHIIP)
325 N. Salisbury Street
Raleigh, NC 27603
1-855-408-1212, TTY: **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: **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: **1-614-644-3745**
https://insurance.ohio.gov/wps/portal/gov/odi/agents-and-agencies

Oklahoma

Senior Health Insurance Counseling Program (SHIP)
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-763-2828, TTY: **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: **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: **711**
http://www.portal.state.pa.us/portal/server.pt?ope

Rhode Island

Senior Health Insurance Program (SHIP)
25 Howard Ave Building 57
Cranston, RI 02920
1-888-884-8721, TTY: **1-401-462-0740**
https://oha.ri.gov/

South Carolina

(I-CARE) Insurance Counseling Assistance and Referrals for Elders
1301 Gervais Street, Suite 350
Columbia, SC 29201
1-800-868-9095, TTY: **711**
https://aging.sc.gov/

South Dakota

Senior Health Information & Insurance Education (SHIINE)
700 Governors Drive
Pierre, SD 57501
1-800-536-8197, TTY: **711**
http://www.shiine.net

Tennessee

TN SHIP
500 Deaderick Street, Suite 825
Nashville, TN 37243-0860
1-877-801-0044, TTY: **711**
http://www.tnmedicarehelp.com/

Texas

Health Information Counseling and Advocacy Program (HICAP)
701 W 51st Street
Austin, TX 78751
1-800-252-9240, TTY: **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: **711**
http://daas.utah.gov/senior-services/

Vermont

State Health Insurance Assistance Program
280 State Drive HC2 South
Waterbury, VT 05671
1-800-642-5119, TTY: **711**
https://www.nekcouncil.org/contact-the-nek-council-on-aging

Virginia

Virginia Insurance Counseling and Assistance Program (VICAP)
1610 Forest Avenue, Suite 100
Henrico, VA 23229
1-800-552-3402, TTY: **711**
http://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: **711**
http://www.insurance.wa.gov

West Virginia

West Virginia State Health Insurance Assistance Program (WV SHIP)
1900 Kanawha Blvd. E
Charleston, WV 25305
1-877-987-4463, TTY: **711**
http://www.wvship.org

Wisconsin

Wisconsin SHIP (SHIP)
One West Wilson Street
Madison, WI 53703
1-800-242-1060, TTY: **711**
https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)
106 W Adams, P.O. Box BD
Riverton, WY 82501
1-800-856-4398, TTY: **711**
http://www.wyomingseniors.com

SECTION 2 Quality Improvement Organization (QIO)

The following state agency information was updated on July 11, 2022. For more recent information or other questions, please contact Member Services.

Alabama

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Alaska

KEPRO Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. -5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Arizona

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Arkansas

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

California

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Colorado

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Connecticut

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Delaware

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

District of Columbia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Florida

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Georgia

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Hawaii

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Idaho

KEPRO - Region 10
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Illinois

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Indiana

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Iowa

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Kansas

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Kentucky

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Louisiana

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Maine

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Maryland

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Massachusetts

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Michigan

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Minnesota

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Mississippi

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Missouri

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Montana

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Nebraska

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Nevada

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

New Hampshire

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

New Jersey

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-866-815-5440, TTY: **1-866-868-2289**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

New Mexico

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

New York

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-866-815-5440, TTY: **1-866-868-2289**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

North Carolina

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

North Dakota

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Ohio

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Oklahoma

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Oregon

KEPRO - Region 10
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Pennsylvania

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Rhode Island

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

South Carolina

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

South Dakota

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Tennessee

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Texas

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Utah

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Vermont

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Virginia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Washington

KEPRO - Region 10
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

West Virginia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Wisconsin

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Wyoming

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

SECTION 3 State Medicaid Offices

The following state agency information was updated on July 11, 2022. For more recent information or other questions, please contact Member Services.

Alabama

Alabama Medicaid Agency
P.O. Box 5624
501 Dexter Avenue
Montgomery, AL 36130-5624
1-334-242-5000, TTY: **1-800-253-0799**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.medicaid.alabama.gov

Alaska

Alaska Medicaid
3601 C Street
Anchorage, AK 99503
1-907-465-3347, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://dhss.alaska.gov/Commissioner/Pages/Contacts/default.aspx

Arizona

Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034
1-800-523-0231, TTY: **711**
8:00 a.m. - 1:00 p.m. and 2:00 p.m. to 5:00 p.m. Monday through Friday
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: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
https:// humanservices.arkansas.gov/divisions-shared-services/medical-services/contact-dms-2/

California

Medi-Cal
P.O. Box 997417 MS 4607
Sacramento, CA 95899-7417
1-800-541-5555, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.medi-cal.ca.gov

Colorado

Colorado Medicaid
1570 Grant Street
Denver, CO 80203
1-800-221-3943, TTY: **711**
8:00 a.m. - 4:30 p.m. Mon - Fri;
8:00 a.m. - 12:00 p.m. Sat
https://www.healthfirstcolorado.com/

Connecticut

HUSKY Health Program
P.O. Box 5005
Wallingford, CT 06492
1-800-859-9889, TTY: **1-866-492-5276**
8:00 a.m. - 6:00 p.m. Monday through Friday
http://www.ct.gov/hh/site/default.asp

Delaware

Delaware Medicaid
Lewis Building
1901 N. DuPont Highway
New Castle, DE 19720
1-800-372-2022, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.dhss.delaware.gov/dhss/dmma/medicaid.html

District of Columbia

DC Medicaid
441 4th Street, NW, 900S
Washington, DC 20001
1-202-442-5988, TTY: **711**
8:15 a.m. - 4:45 p.m. Monday through Friday
http://dhcf.dc.gov/service/what-medicaid

Florida

Florida Medicaid
2727 Mahan Drive MS#6
Tallahassee, FL 32308
1-888-419-3456, TTY: **1-800-955-8771**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.ahca.myflorida.com/Medicaid/index.shtml/about

Georgia

Georgia Medicaid
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
1-877-423-4746, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://medicaid.georgia.gov/

Hawaii

Department of Human Services Med-QUEST Division
820 Mililani Street, Suite 606
Honolulu, HI 96813
1-800-316-8005, TTY: **1-855-585-8604**
9:00 a.m. - 3:00 p.m. Monday through Friday
https://medquest.hawaii.gov/

Idaho

Idaho Medicaid
P.O. Box 83720
Boise, ID 83720
1-877-456-1233, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://healthandwelfare.idaho.gov/ContactUs/tabid/127/Default.aspx

Illinois

Illinois Medicaid
100 South Grand Avenue East
Springfield, IL 62762
1-800-843-6154, TTY: **711**
8:30 a.m. - 5:00 p.m. Monday through Friday
http://www.hfs.illinois.gov/medical/apply.html

Indiana

Indiana Medicaid
P.O. Box 7083
402 W Washington Street
Indianapolis, IN 46204
1-800-457-4584, TTY: **711**
8:00 a.m. - 6:00 p.m. Mon - Fri
http://member.indianamedicaid.com/

Iowa

Iowa Medicaid
P.O. Box 36510
Des Moines, IA 50315
1-800-338-8366, TTY: **1-800-735-2942**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.dhs.iowa.gov

Kansas

KanCare
503 S. Kansas Ave.
Topeka, KS 66603
1-800-432-3535, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.kancare.ks.gov/

Kentucky

Kentucky Medicaid
275 East Main Street
Frankfort, KY 40621
1-855-306-8959, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.chfs.ky.gov

Louisiana

Louisiana Medicaid
P.O. Box 629
Baton Rouge, LA 70821-9278
1-888-342-6207, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://ldh.la.gov/

Maine

MaineCare
11 State House Station
Augusta, ME 04333-0011
1-800-977-6740, TTY: **711**
7:00 a.m. - 6:00 p.m. Monday through Friday
http://www.maine.gov/dhhs/oms/index.shtml

Maryland

Maryland Medicaid
201 West Preston Street
Baltimore, MD 21201
1-877-463-3464, TTY: **711**
8:30 a.m. - 5:00 p.m. Monday through Friday
https://health.maryland.gov/pages/index.aspx

Massachusetts

MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108
1-800-841-2900, TTY: **1-800-497-4648**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.mass.gov/eohhs/gov/departments/masshealth/

Michigan

Michigan Medicaid
P.O. Box 30195,
333 S. Grand Ave
Lansing, MI 48909
1-866-275-6424, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.michigan.gov/mdch/0,4612,7-132-2943_4860—,00.html

Minnesota

Minnesota's Medical Assistance Program
PO Box 64838
St. Paul, MN 55164
1-800-657-3739, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://mn.gov/dhs/general-public/about-dhs/contact-us/division-addresses.jsp

Mississippi

Mississippi Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
1-800-421-2408, TTY: **711**
7:30 a.m. - 5:00 p.m. Monday through Friday
http://www.medicaid.ms.gov

Missouri

MO HealthNet
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102-6500
1-855-373-4636, TTY: **711**
6:00 a.m. - 6:30 p.m. Monday through Friday
https://dss.mo.gov/

Montana

Montana Medicaid and Healthy Montana Kids (HMK) Plus
P.O. Box 202925
Helena, MT 59457
1-800-362-8312, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.dphhs.mt.gov

Nebraska

Nebraska Medicaid
301 Centennial Mall South
Lincoln, NE 68509-5026
1-855-632-7633, TTY: **1-800-833-7352**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://dhhs.ne.gov/Pages/Medicaid-Services.aspx

Nevada

Nevada Medicaid
1100 East William Street Suite 101
Carson City, NV 89701
1-877-638-3472, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://dhcfp.nv.gov/

New Hampshire

NH Medicaid
129 Pleasant Street
Concord, NH 03301
1-800-852-3345, TTY: **1-800-735-2964**
8:00 a.m. – 4:30 p.m. Monday through Friday
http://www.dhhs.state.nh.us/ombp/medicaid/index.htm

New Jersey

Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712
1-800-701-0710, TTY: **711**
Monday and Thursday 8:00 a.m. - 8:00 p.m.
Tuesday, Wednesday, Friday 8:00 a.m. - 5:00 p.m.
http://www.state.nj.us/humanservices/dmahs

New Mexico

NM Human Services Dept.
P.O. Box 2348
Santa Fe, NM 87504-2348
1-800-283-4465, TTY: **1-855-227-5485**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.hsd.state.nm.us/

New York

New York Medicaid
Corning Tower, Empire State Plaza
Albany, NY 12237
1-800-541-2831, TTY: **711**
8:00 a.m. - 8:00 p.m. Monday through Friday
9:00 a.m. - 1:00 p.m. Saturday
http://www.health.ny.gov/health_care/medicaid/

North Carolina

North Carolina Medicaid
2501 Mail Service Center
Raleigh, NC 27699-2501
1-888-245-0179, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://dma.ncdhhs.gov/

North Dakota

North Dakota Medicaid
600 E. Boulevard Avenue, Dept 325
Bismarck, ND 58505-0250
1-800-755-2604, TTY: **1-800-366-6888**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.nd.gov/dhs/services/medicalserv/medicaid/

Ohio

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, OH 43215
1-800-324-8680, TTY: **1-800-292-3572**
7:00 a.m. - 8:00 p.m. Monday through Friday
http://medicaid.ohio.gov/

Oklahoma

Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105
1-888-365-3742, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.insureoklahoma.org

Oregon

Oregon Department of Human Services
500 Summer Street, NE, E-20
Salem, OR 97301-1097
1-800-375-2863, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
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: **1-800-451-5886**
8:30 a.m. - 4:45 p.m. Monday through Friday
http://www.dhs.pa.gov/

Rhode Island

Rhode Island Medicaid
3 West Road
Cranston, RI 02920
1-855-697-4347, TTY: **1-800-745-5555**
8:30 a.m. - 3:30 p.m. Monday through Friday
http://www.dhs.ri.gov/

South Carolina

Healthy Connections
P.O. Box 8206
Columbia, SC 29202
1-888-549-0820, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.scdhhs.gov/

South Dakota

South Dakota Medicaid
700 Governors Drive, Richard F Kneip Bldg
Pierre, SD 57501
1-800-597-1603, TTY: **711**
8:00 a.m. - 6:00 p.m. Monday through Friday
http://dss.sd.gov/medicaid/

Tennessee

TennCare
310 Great Circle Road
Nashville, TN 37243
1-800-342-3145, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.tn.gov/tenncare

Texas

Texas Health and Human Services
P. O. Box 13247
Austin, TX 78711-3247
1-800-252-8263, TTY: **711**
7:00 a.m. - 7:00 p.m. Mon - Fri
http://www.hhsc.state.tx.us/medicaid/index.shtml

Utah

Utah Department of Health Medicaid
Division of Medicaid and Health Financing
P.O. Box 143106
Salt Lake City, UT 84114
1-801-538-6155, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
(Thursday 11:00 a.m. - 5:00 p.m.)
https://medicaid.utah.gov/

Vermont

Green Mountain Care
280 State Drive
Waterbury, VT 05671-1010
1-802-879-5900, TTY: **711**
7:45 a.m. - 4:30 p.m. Monday through Friday
https://dvha.vermont.gov/

Virginia

Virginia Medicaid
600 East Broad Street
Richmond, VA 23219
1-833-522-5582, TTY: **1-888-221-1590**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.dmas.virginia.gov/#/index

Washington

Washington Apple Health
P.O. Box 45531
Olympia, WA 98504
1-800-562-3022, TTY: **711**
7:00 a.m. - 5:00 p.m. Monday through Friday
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
1-304-558-1700, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.dhhr.wv.gov/bms/Pages/default.aspx

Wisconsin

Wisconsin Medicaid
1 West Wilson Street
Madison, WI 53703
1-800-362-3002, TTY: **1-800-947-3529**
8:00 a.m. - 6:00 p.m. Monday through Friday
https://www.dhs.wisconsin.gov/

Wyoming

Wyoming Medicaid
P.O. Box 667
Cheyenne, WY 82003
1-800-251-1269, TTY: **1-307-777-7531**
9:00 a.m. - 5:00 p.m. Monday through Friday
http://health.wyo.gov

SECTION 4 State Medicare Offices

The following state agency information was updated on July 11, 2022. For more recent information or other questions, please contact Member Services.

All 50 U.S. States and Washington, D.C.

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
1-800-633-4227, TTY: 1**-877-486-2048**
24 hours, 7 days a week
www.medicare.gov

SECTION 5 State Pharmaceutical Assistance Program (SPAP)

The following state agency information was updated on July 11, 2022. For more recent information or other questions, please contact Member Services.

Alabama

Alabama SenioRx Prescription Assistance program
201 Monroe Street, Suite 350
Montgomery, AL 36104
1-877-425-2243 , TTY: **711**
8:00 a.m. to 5:00 p.m. from Monday through Friday
https://www.alabamaageline.gov/seniorx/

Arkansas

Pharmacy Services
P.O. Box 1437
Little Rock, AR 72203
1-501-682-6327
8:00 a.m. - 5:00 p.m.
https://humanservices.arkansas.gov/announcements/pharmacy-services/

California

The Board of Pharmacy's
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
1-916-518-3100; TTY: **711**
Monday-Friday 8:00am to 5:00pm
https://www.pharmacy.ca.gov/consumers/medicare_discount.shtml

Colorado

Community Pharmacist Integration
4300 Cherry Creek Drive South
Denver, CO 80246
1-800-886-7689; TTY: **711**
7:00 a.m. - 3:00 p.m., Monday through Friday
https://cdphe.colorado.gov/community-pharmacist-integration

Delaware

Delaware Prescription Assistance Program
P.O. Box 950
New Castle, DE 19720-0950
1-800-996-9969, TTY: **711**
8:00 a.m. - 4:30 p.m.
http://www.dhss.delaware.gov/dhss/dmma/dpap.html

Hawaii

Prescription Drug Coverage
201 Merchant Street, Suite 1700
Honolulu, HI 96813
1-800-295-0089, TTY: **711**
8:00 a.m. - 5:00 p.m.
eutf.hawaii.gov/important-notices/prescription-drug-coverage-medicare-notice-retiree/

Idaho

Idaho State Pharmacy Assistance Programs (SPAP)
P. O. Box 83720
Boise, ID 83720
1-208-364-1962
8:00 a.m. - 5:00 p.m.
https://q1medicare.com/PartD-SPAPIdahoStatePharmAssistProgram.php

Illinois

Illinois State Pharmacy Assistance Programs
P.O. Box 19022
Springfield, IL 62794
1-800-624-2459
8:00 a.m. - 5:00 p.m.
https://q1medicare.com/PartD-SPAPIllinoisProgsElderlyDisabled.php

Indiana

HoosierRx
P.O. Box 6224
Indianapolis, IN 46206-6224
1-800-378-0779, TTY: **711**
7:00 a.m. - 3:00 p.m., ET Monday through Friday
http://www.in.gov

Iowa

Iowa Board of Pharmacy
400 S.W. Eighth Street, Ste. E
Des Moines, IA 50309-4688
1-515-281-5944
8:00 a.m. - 4:30 p.m.
https://pharmacy.iowa.gov/

Kansas

Kansas Medicaid (KanCare and KMAP) Pharmaceutical Program
900 SW Jackson, Suite 900 N
Topeka, KS 66612
1-785-296-3982, TTY: 711
8:00 a.m. - 5:00 p.m.
https://www.kdhe.ks.gov/188/Pharmacy

Kentucky

Pharmacy Program and Services
275 E. Main St, 6W-D
Frankfort, KY 40621
1-502-564-6890, TTY: **711**
8:00 a.m. - 5:00 p.m.
https://chfs.ky.gov/agencies/dms/dpo/ppb/Pages/default.aspx

Louisiana

Louisiana Board of Pharmacy
3388 Brentwood Drive
Baton Rouge, LA 70809
1-225-925-6496
8:00 a.m. - 5:00 p.m.
http://www.pharmacy.la.gov/

Maine

Medical & Prescriptions
61 State House Station
Augusta, ME 04333-0061
1-800-595-0817; TTY: **711**
8:00 a.m. - 4:30 p.m. M-F
https://www.maine.gov/bhr/oeh/benefits/health-prescriptions

Maryland

Maryland Senior Prescription Drug Assistance Program (SPDAP)
PO Box 749
Greenbelt, MD 20768
1-800-877-5156, TTY: **711**
8:00 a.m. - 5:00 p.m.
http://www.marylandspdap.com

Massachusetts

Massachusetts Prescription Advantage
P.O. Box 15153
Worcester, MA 01615-0153
1-800-243-4636, TTY: **1-877-610-0241**
9:00 a.m. - 5:00 p.m.
http://www.mass.gov/elders/healthcare/prescription-advantage/

Michigan

Prescription Task Force
333 S. Grand Ave
Lansing, MI 48909
1-517-241-3740, TTY: **711**
8:00 a.m. - 5:00 p.m.
https://www.michigan.gov/mdhhs/0,5885,7-339--352302--,00.html

Minnesota

Board of Pharmacy
335 Randalph Avenue, Suite #230
St. Paul, MN 55102
1-651-201-2858, TTY: **711**
8:00 a.m. - 5:00 p.m.
https://mn.gov/boards/pharmacy/public/savingonprescriptiondrugs.jsp

Montana

Big Sky Rx Program
P.O. Box 202915
Helena, MT 59620-2915
1-406-444-0273, TTY: **711**
8:00 a.m. - 5:00 p.m.
dphhs.mt.gov/montanahealthcareprograms/prescriptiondrugassistance/

Nebraska

Prescription Drug Coverage & Management
3835 Holdrege Street
Lincoln, NE 68583
1-402-472-2111, TTY: **711**
8:00 a.m. - 5:00 p.m.
https://nebraska.edu/faculty-and-staff/health-benefits/prescription-drug-coverage-management

Nevada

Aging and Disability Services Division - Senior Rx and Disability Rx
3320 W. Sahara Ave, Ste. 100
Las Vegas, NV 89102
1-866-303-6323, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/

New Jersey

New Jersey State Pharmaceutical Assistance Programs - PAAD and Senior Gold
P.O. Box 715
Trenton, NJ 08625-0715
1-800-792-9745, TTY: **711**
8:00 a.m. - 4:30 p.m.
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: **711**
8:00 a.m. - 5:00 p.m.
http://www.health.ny.gov/health_care/epic

North Carolina

North Carolina State Pharmacy Assistance Programs (SPAP)
1902 Mail Service Center
Raleigh, NC 27699
1-877-466-2232
8:30 a.m. - 5:00 p.m.
https://q1medicare.com/PartD-SPAPNorthCarolinaNCPharmRxAssist.php

Ohio

Ohio's Best Rx
246 N. High St.
Columbus, OH 43215
1-866-923-7879, TTY: **711**
8:00 a.m. - 5:00 p.m.
https://ohio.gov/residents/resources/ohios-best-ohiobestrx

Oklahoma

Oklahoma State Board of Pharmacy
2920 N Lincoln Blvd, Ste A
Oklahoma City, OK 73105
1-405-521-3815, TTY: **711**
8:00 a.m. - 4:30 p.m.
ok.gov/pharmacy/Board/Contact/index.html

Oregon

Oregon Board of Pharmacy
800 NE Oregon St., Suite 150
Portland, OR 97232
1-971-673-0001, TTY: **711**
8:30 a.m. - 4:00 p.m.
https://www.oregon.gov/pharmacy/pages/index.aspx

Pennsylvania

Pennsylvania Department of Aging Bureau of Pharmaceutical Assistance
P.O. Box 8806
Harrisburg, PA 17105-8806
1-800-225-7223, TTY: **1-800-222-9004**
8:30 a.m. - 5:00 p.m.
http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Rhode Island

Drug Cost Assistance
25 Howard Ave, Building 57
Cranston, RI 02920
1-401-462-3000
8:30 a.m. - 4:00 p.m.
https://oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance

South Dakota

Prescription Drug Support Part D
700 Governors Drive
Pierre, SD 57501
1-605-773-3165, TTY: **711**
8:00 a.m. - 5:00 p.m.
https://dss.sd.gov/medicaid/recipients/medicarepartD/

Vermont

PRESCRIPTION ASSISTANCE
280 State Drive
Waterbury, VT 05671-1500
1-800-250-8427, TTY: **711**
7:45 a.m. - 4:30 p.m.
https://dvha.vermont.gov/members/prescription-assistance

Wisconsin

Wisconsin Senior Care
1 West Wilson Street
Madison, WI 53703
1-608-266-1865, TTY: **711**
8:00 a.m. - 6:00 p.m.
https://www.dhs.wisconsin.gov/seniorcare/index.htm

SECTION 6 Civil Rights Commission

The following state agency information was updated on July 11, 2022. For more recent information or other questions, please contact Member Services.

Alabama

Office for Civil Rights of the Southeast Region – Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. -4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Alaska

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. –8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Arizona

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Arkansas

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

California

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Colorado

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Connecticut

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Delaware

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

District of Columbia

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Florida

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Georgia

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Hawaii

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Idaho

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Illinois

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Indiana

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Iowa

Office for Civil Rights of the Midwest Region
233 N. Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Kansas

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Kentucky

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Louisiana

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Maine

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Maryland

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Massachusetts

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Michigan

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Minnesota

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Mississippi

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Missouri

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Montana

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Nebraska

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Nevada

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Hampshire

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Jersey

Office for Civil Rights of Eastern and Caribbean Region
26 Federal Plaza, Suite 3312
New York, NY 10278
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Mexico

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New York

Office for Civil Rights of Eastern and Caribbean Region
26 Federal Plaza, Suite 3312
New York, NY 10278
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

North Carolina

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

North Dakota

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Ohio

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Oklahoma

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Oregon

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Pennsylvania

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Rhode Island

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

South Carolina

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

South Dakota

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Tennessee

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Texas

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Utah

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Vermont

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Virginia

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Washington

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

West Virginia

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Wisconsin

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Wyoming

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

SECTION 7 AIDS Drug Assistance Program (ADAP)

The following state agency information was updated on July 11, 2022. For more recent information or other questions, please contact Member Services.

Alabama

Alabama Public Health
The RSA Tower, 201 Monroe Street
Montgomery, AL 36104
1-800-228-0469, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.adph.org/aids/index.asp?id=995

Alaska

Alaskan AIDS Assistance Association
3601 C Street, Suite 540
Anchorage, AK 99503
1-907-269-8057, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://dhss.alaska.gov/dph/Epi/hivstd/Pages/I2c/default.aspx

Arizona

Arizona Department of Health Services
150 N. 18th Avenue
Phoenix, AZ 85007
1-602-542-1025, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.azdhs.gov/phs/hiv/adap/

Arkansas

Arkansas Department of Health
4815 W. Markham
Little Rock, AR 72205
1-501-661-2408, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.healthy.arkansas.gov/programs-services/topics/infectious-disease

California

California Office of AIDS
P.O. Box 997377, MS 500
Sacramento, CA 95899-7426
1-833-422-4255, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx

Colorado

Colorado AIDS Drugs Assistance Program
4300 Cherry Creek Drive S
Denver, CO 80246
1-303-692-2000, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://cdphe.colorado.gov/state-drug-assistance-program

Connecticut

Connecticut Department of Social Services
Department of Social Services Pharmacy Unit
55 Farmington Avenue
West Hartford, CT 06106-3730
1-800-424-3310, TTY: **711**
8:00 a.m. - 4:00 p.m. Monday through Friday
https://ctdph.magellanrx.com/contact

Delaware

Delaware AIDS Drug Assistance Program ADAP
540 S. DuPont Highway
Dover, DE 19901
1-302-744-1050, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html

District of Columbia

DC Health
889 North Capitol Street NE
Washington, DC 20002
1-202-442-5955, TTY: **711**
8:15 a.m. - 4:45 p.m. Monday through Friday
http://doh.dc.gov/service/dc-aids-drug-assistance-program

Florida

Florida AIDS Drug Assistance Program
4052 Bald Cypress Way, BIN A09
Tallahassee, FL 32399
1-800-352-2437, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.floridahealth.gov/diseases-and-conditions/aids/adap/

Georgia

AIDS Drug Assistance Program
2 Peachtree Street NW
Atlanta, GA 30303-3186
1-404-657-2700, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://dph.georgia.gov/aids-drug-assistance-program-adap-0

Hawaii

HIV Drug Assistance Program
3627 Kilauea Avenue, Suite 306
Honolulu, HI 96816
1-808-733-4079, TTY: **711**
7:45 a.m. - 4:30 p.m. Monday through Friday
https://health.hawaii.gov/harmreduction/contact/

Idaho

Idaho Ryan White Part B Program
P. O. Box 83720
Boise, ID 83720
1-208-334-5612, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://healthandwelfare.idaho.gov/Health/HIV.STD.HepatitisPrograms/HIVCare/tabid/391/Default.aspx

Illinois

Illinois Ryan White Part B Program
535 W. Jefferson Street, First Floor
Springfield, IL 62761
1-217-782-4977, TTY: **1-800-547-0466**
8:30 a.m. - 5:00 p.m. Monday through Friday
http://www.idph.state.il.us/aids/materials/less.htm

Indiana

HIV Services Program
2 North Meridian Street
Indianapolis, IN 46204
1-866-588-4948, TTY: **711**
8:00 a.m. - 4:00 p.m. Monday through Friday
http://www.in.gov/isdh/17740.htm

Iowa

Care & Support Services – The Ryan White Part B Program
321 E. 12th Street
Des Moines, IA 50319-0075
1-515-281-7689, TTY: **711**
8:00 a.m. - 4:00 p.m. Monday through Friday
http://www.idph.iowa.gov/hivstdhep/hiv

Kansas

The Kansas Ryan White Part B Program
1000 SW Jackson, Suite 540
Topeka, KS 66612
1-785-296-1086, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program-ADAP

Kentucky

HIV/AIDS Services Program
275 E Main Street, HS2E-C
Frankfort, KY 40621
1-800-420-7431, TTY: **1-502-564-9865**
8:00 a.m. - 4:00 p.m. Monday through Friday
https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

Louisiana

Louisiana Health Access Program (LA HAP)
628 N. 4th Street
Baton Rouge, LA 70802
1-225-342-9500, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://new.dhh.louisiana.gov/index.cfm/page/919

Maine

Ryan White Part B Program
40 State House Station
Augusta, ME 04330
1-207-287-3747, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
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: **711**
8:30 a.m. - 4:30 p.m. Monday through Friday
http://phpa.dhmh.maryland.gov/OIDPCS/CHCS/Pages/madap.aspx

Massachusetts

HIV Drug Assistance Program HDAP
529 Main Street Suite 301
Charlestown, MA 02129
1-617-502-1700, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://crine.org/hdap/

Michigan

Michigan HIV/AIDS Drug Assistance Program (MIDAP)
109 Michigan Avenue, 9th Floor
Lansing, MI 48913
1-888-826-6565, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://michigan.gov/mdch/0,1607,7-132-2940_2955_2982-44913–,00.html

Minnesota

Medication Program (ADAP)
HIV/AIDS Programs, Department of Human Services
P.O. Box 64972
St Paul, MN 55164-0972
1-651-431-2414, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp

Mississippi

Mississippi State Department of Health
570 East Woodrow Wilson Drive, P.O. Box 1700
Jackson, MS 39215-1700
1-866-458-4948, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
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: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php

Montana

The Ryan White HIV/AIDS Program
1400 Broadway, Cogswell Bldg C-211
Helena, MT 59620-2951
1-800-232-4646, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
dphhs.mt.gov/contact/hotlinenumbers

Nebraska

Nebraska Department of Health & Human Services - AIDS Drug Assistance Program
P.O. Box 95026
Lincoln, NE 68509-5026
1-402-471-2101, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
https://dhhs.ne.gov/Pages/Ryan-White.aspx

Nevada

Ryan White Part B Programs and Services
1840 E. Sahara
Suite 110-111
Las Vegas, NV 89104
1-702-486-0767, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/

New Hampshire

Department of Health and Human Services - Ryan White CARE Program
2 Blacksmith Street
Lebanon, NH 03766
1-603-448-8887, TTY: **711**
8:30 a.m. - 4:30 p.m. Monday through Friday
http://www.h2rc.org/contact-us

New Jersey

New Jersey Department of Health
New Jersey Health Insurance Continuation Program
P.O. Box 360
Trenton, NJ 08625-0360
1-800-624-2377, TTY: **711**
8:30 a.m. - 5:00 p.m. ET
https://www.state.nj.us/health/hivstdtb/

New Mexico

New Mexico AIDS Drug Assistance Program
1190 S. St. Francis Drive, Suite 1200
Santa Fe, NM 87505
1-505-827-2435, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://nmhealth.org/contact/staff/

New York

HIV Uninsured Care Program
Empire Station, P.O. Box 2052
Albany, NY 12220-0052
1-800-542-2437, TTY: **1-518-459-0121**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm

North Carolina

HIV Medication Assistance Program (HMAP)
1902 Mail Service Center
Raleigh, NC 27699-1902
1-919-733-3419, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://epi.publichealth.nc.gov/cd/hiv/adap.html

North Dakota

North Dakota Ryan White HIV/AIDS Part B Program
2635 East Main Avenue
Bismarck, ND 58501
1-800-472-2180, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.ndhealth.gov/HIV/

Ohio

Ohio HIV Drug Assistance Program
246 N. High Street
Columbus, OH 43215
1-800-777-4775, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/

Oklahoma

Oklahoma Ryan White Program
123 Robert S. Kerr Ave.
Oklahoma City, OK 73102-6406
1-405-426-8400, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
oklahoma.gov/health/prevention-and-preparedness/sexual-health-and-harm-reduction-service/care-delivery-ryan-white-adap-hepatitis.html

Oregon

CAREAssist Program
800 NE Oregon Street Suite 1105
Portland, OR 97232
1-971-673-0144, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/CAREASSIST/Pages/Program-Information.aspx

Pennsylvania

Pennsylvania Department of Health
Human Immunodeficiency Virus (HIV) Services and Epidemiology
625 Forster Street
Harrisburg, PA 17120
1-717-783-0572, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday to Friday
https://www.health.pa.gov/topics/programs/HIV/Pages/HIV.aspx

Rhode Island

Ryan White AIDS Drug Assistance Program (ADAP)
RI Executive Office of Health and Human Services
3 West Road
Cranston, RI 02920
1-855-840-4774, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
eohhs.ri.gov/about-eohhs/contact

South Carolina

South Carolina AIDS Drug Assistance Program
SC Drug Assistance Program/Insurance Assistance Program
2600 Bull Street
Columbia, SC 29201
1-800-856-9954, TTY: **711**
9:30 a.m. - 5:30 p.m. Monday through Friday
https://www.dhec.sc.gov/health/infectious-diseases/hiv-std-viral-hepatitis/aids-drug-assistance-plan

South Dakota

Ryan White Part B CARE Program
615 E. 4th Street
Pierre, SD 57501-1700
1-800-592-1861, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://doh.sd.gov/diseases/infectious/ryanwhite/

Tennessee

Ryan White Program
710 James Robertson Parkway
Nashville, TN 37243
1-615-741-7500, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://tn.gov/health

Texas

Texas Health and Human Services
P.O. Box 149347, MSJA MC 1873
Austin, TX 78714-9347
1-737-255-4300, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.dshs.state.tx.us/hivstd/default.shtm

Utah

Bureau Of Epidemiology
288 North 1460 West, P.O. Box 142104
Salt Lake City, UT 84114-2104
1-801-538-6191, TTY: **711**
9:00 a.m. - 5:00 p.m. Monday through Friday
https://epi.health.utah.gov/hiv-aids/

Vermont

AIDS AND HIV SERVICE ORGANIZATIONS IN VERMONT
108 Cherry Street, P.O. Box 70
Burlington, VT 05402
1-802-863-7240, TTY: **711**
7:45 a.m. - 4:45 p.m. Monday through Friday
http://healthvermont.gov/prevent/aids/aids_index.aspx

Virginia

Virginia AIDS Drug Assistance Program (ADAP)
Virginia Dept of Health, HCS Unit
109 Governor Street
Richmond, VA 23219
1-800-533-4148, TTY: **711**
8:00 a.m. - 6:00 p.m. Monday and Wednesday
8:00 a.m. - 5:00 p.m. Tuesday, Thursday, Friday
https://www.vdh.virginia.gov/contact-us/

Washington

Washington State Department of Health - Early Intervention Program (EIP)
EIP Client Services
P.O. Box 47841
Olympia, WA 98504
1-877-376-9316, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services

West Virginia

AIDS Drug Assistance Program
350 Capitol Street, Room 125
Charleston, WV 25301
1-304-232-6822, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://oeps.wv.gov/rwp/pages/default.aspx

Wisconsin

Wisconsin Department of Health and Human Services AIDS/HIV Assistance Program
Division of Public Health, Attn: ADAP
1 West Wilson Street
P.O. Box 2659
Madison, WI 53701-2659
1-608-266-1865, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.dhs.wisconsin.gov/contacts.htm

Wyoming

Wyoming Department of Health
Wyoming Department of Health, Communicable Disease Unit
401 Hathaway Building
Cheyenne, WY 82002
1-866-571-0944, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
health.wyo.gov/department-promoting-hiv-prevention-medication/

Multi-Language Insert

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 **1-866-470-6265** سيقوم شخص ما يتحدث العربية . بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-866-470-6265** पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त 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 Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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。

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Anthem

Pharmacy Member Services - Contact Information

Call: For questions related to pharmacy benefits, please call us at 1-833-285-4636.

Calls to this number are free. 24 hours a day, 7 days a week

Member Services 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: CarelonRx
ATTN: Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

Member Services - 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

Member Services also has free language interpreter services available for non-English speakers.

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.

Fax: 1-855-358-1226

Write: Blue Cross MedicareRx (PDP) with Senior Rx Plus
P.O. Box 173144
Denver, CO 80217-3144

Website: www.anthem.com/ca

State Health Insurance Program

State Health Insurance Programs are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare. See the "State organization contact information" chapter located at the back of this document to find the information for your state.