Evidence of Coverage

Effective January 1, 2027

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, 2027 - December 31, 2027

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

This document gives you the details about your Medicare drug coverage and non-Medicare supplemental drug coverage from January 1, 2027 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

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

- Your plan premium and cost sharing
- Your drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at **1-866-470-6265,** TTY users, call **711**, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays, or visit **www.anthem.com/ca**. This call is free.

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. Call the Member Services listed above to request interpreter services.

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

If applicable, benefits, premiums, deductibles, and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Our formulary and pharmacy network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

Your 2027 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.

Benefit Period	January 1, 2027 – December 31, 2027
Deductible	$100 per calendar year
CMS Defined Drug Out-of-Pocket Limit	$2,400 per calendar year

Part D Initial Coverage

After you meet your deductible, this is what you pay for covered drugs until you reach your out-of-pocket limit. You will pay this amount or the cost of the drug, whichever is less.

Pharmacy	**Standard Network Pharmacy**		**Mail-Order Pharmacy**
	per 30-day supply	**per 90-day supply**	**per 90-day supply**
Tier 1: Generics Deductible waived	$10	$30	$20
Tier 2: Preferred Drugs	$25	$75	$40
Tier 3: Non-Preferred Drugs, including Specialty Drugs	$45	$135	$75
Select Generics Deductible waived	$0	$0	$0

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 pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will pay two 30-day copays.

Part D Catastrophic Coverage

Your payment responsibility changes after the amount you have paid for covered drugs reaches your **CMS defined drug out-of-pocket limit** of $2,400.

Retail and Mail-Order Pharmacies	**Up to a 90-day supply**
All Part D Covered Prescription Drugs	$0

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.
- **Important Message About What You Pay for Insulin:** You won't pay more than $35 for a one-month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.
- **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 Part B medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare Part D drug coverage. Hepatitis B is covered under Medicare Part D drug coverage unless you fall into a high risk category, then it is covered under Medicare Part B medical coverage. Other common vaccines are also

covered under Medicare Part D 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. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.
- **Select Generics:** Your plan includes the $0 copay Select Generics benefit. Select Generics are a specific list of drugs that have been on the market long enough to have a proven track record for effectiveness and value. These generic drugs treat common conditions like diabetes, high blood pressure, high cholesterol, and osteoporosis. The Select Generics benefit is designed to help you better manage your chronic conditions and reduce out-of-pocket costs on prescription medications.

Your 2027 Extra Covered Drugs Benefits Chart

Extra Covered Drugs

These prescription drugs are not covered under Part D, but they are provided under your Senior Rx Plus benefits. There may be instances where state regulations require these drugs to be included in your plan. These drugs do not count towards your deductible or **CMS defined drug out-of-pocket limit** of $2,400.

Pharmacy	**Retail Pharmacy**	**Mail-Order Pharmacy**
	per 30-day supply	**per 90-day supply**
Cough and Cold **DESI** **Vitamins and Minerals**		
Tier 1: Generics	$10	$20
Tier 2: Preferred Drugs	$25	$40
Tier 3: Non-Preferred Drugs	$45	$75
Erectile Dysfunction (ED)	**Immediate dose ED drugs** **Immediate dose formats are limited to 6 per 30 days.**	
Tier 1: Generics	$10	$20
Tier 2: Preferred Drugs	$25	$40
Tier 3: Non-Preferred Drugs	$45	$75
Other Non-Part D Coverage		
Contraceptive Devices Limit 1 per year	33%	33%
Non-Part D Diabetic Supplies – Lancets, Blood Sugar Diagnostics and Calibration Solutions	$25	$40
Non-Part D Diabetic Supplies - Glucometers	$25	$25

- **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.

2027 Evidence of Coverage

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Blue Cross MedicareRx (PDP) with Senior Rx Plus

Section 1.1 You're enrolled in Blue Cross MedicareRx (PDP) with Senior Rx Plus, which is a group-sponsored Medicare PDP 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 drug plan (also called Group Part D or PDP). Like all Medicare plans, this Medicare 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 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 get 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.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of your plan after December 31, 2027, or on your group-sponsored plan's renewal date. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B).
- You live in our geographic service area (described in Section 2.2). explains Medicare Part A and Medicare Part B. People who are incarcerated aren't considered to be living-in the geographic service area even if they're physically located in it.

- You're a United States citizen or national, or an eligible noncitizen.
- - 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 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 Plan service area for our plan

Your plan is only available to people who live in the service area. To stay a member of our group-sponsored plan, you must continue to live 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 move out of the service area, you can't stay a member of this plan. Call 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.

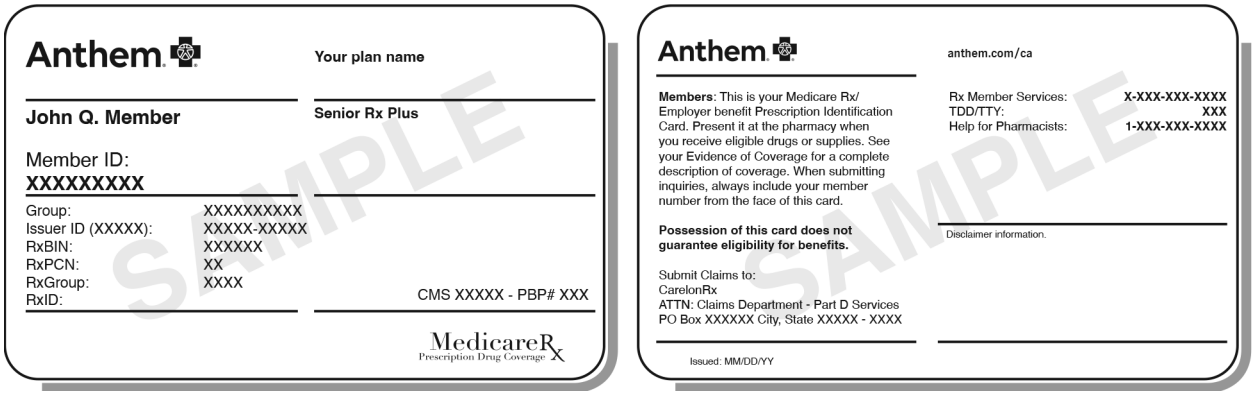
Section 2.4 U.S. citizen or national, or an eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Cross MedicareRx (PDP) with Senior Rx Plus if you're not eligible to stay a member of our plan on this basis. Blue Cross MedicareRx (PDP) with Senior Rx Plus must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our pharmacy plan ID card

Use your pharmacy plan ID card for prescription drugs you get at network pharmacies. Sample ID card:



Carry your ID card with you at all times and remember to show it when you get covered drugs. If our ID card is damaged, lost, or stolen, call Member Services right away and we'll 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 in-network pharmacies. In-network pharmacies are pharmacies that agree to fill covered prescriptions for our plan members. Use the Pharmacy Directory to find the in-network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our 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 ask for a copy from Pharmacy Member Services. You can also find this information on **www.anthem.com/ca**.

Section 3.3 Drug List (formulary)

The plan has a List of Covered Drugs (also called Drug List or formulary). It explains which 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 doctors and pharmacists. The Drug List meets all Medicare's requirements. Drugs included in the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 3, Section 6. Medicare approved this plan's Drug List.

The Drug List also explains if there are any rules that restrict coverage for a drug.

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

SECTION 4 Summary of important costs for 2027

The Benefits Chart located at the front of this document lists your covered services and shows how much you will pay for each covered service as a member of your plan.

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)
- Medicare Prescription Payment Plan amount (Section 4.5)

Section 4.1 Plan premium

Your coverage is provided through a contract with your group sponsor. 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, contact Member Services.

In some situations, your plan premium could be less.

If you are already enrolled and getting help from one of these programs, we will send you a separate insert, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, 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, contact your SPAP to determine what help is available to you. For contact information, 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 2027 handbook, the section called 2027 Medicare Costs. If you need a copy you can download it from the Medicare website (**www.medicare.gov/medicare-and-you**). Or, you can order a printed copy by phone at **1-800-MEDICARE** (**1-800-633-4227**), TTY users call **1-877-486-2048**.

Section 4.2 Monthly Medicare Part B premium

Some members are required to pay other Medicare premiums

You must have either Part A and/or Part B to be enrolled in Part D plan. Although most people do not have to pay for Part A, some do. If you have to pay for Part A, you must also have Part B, and you must continue paying your Medicare premiums to stay a member of our plan.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2027 handbook, the section called 2027 Medicare Costs. If you need a copy you can download it from the Medicare website (**www.medicare.gov/medicare-and-you**). Or, you can order a printed copy by phone at **1-800-MEDICARE** (**1-800-633-4227**), 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 at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't 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 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'll generally have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to the plan premium. Contact your group sponsor to find out if you have a late enrollment penalty and who will be responsible for paying it. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay for your drug cost.
- You went less than 63 days in a row without Part D or other creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from our plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.
    - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's 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, our plan will count the number of full months you didn't have coverage.
- Then, Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year. For 2026, this average premium amount was $38.99. This amount may change for 2027.
- To calculate your monthly penalty. Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds the amount to the nearest 10 cents. For the example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times $38.99, which equals $5.46. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty.**

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year**, because the national base beneficiary premium can change each year.
- **You'll generally continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're under 65 and enrolled in Medicare, 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 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 reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you won't have another chance to ask for a reconsideration 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, (IRMAA). The extra charge is calculated 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 **www.Medicare.gov/health-drug-plans/part-d/basics/costs**.

If you have to pay an extra IRMAA, 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'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at **1-800-772-1213,** TTY users call **1-800-325-0778**.

Section 4.5 Medicare Prescription Payment Plan Amount

If you are participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 8 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 7 to make a complaint or appeal.

SECTION 5 Your monthly plan premium won't change 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. 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.

SECTION 6 Keep your plan membership record up to date

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

The pharmacists in your plan's **use your membership record to know what drugs are covered and the cost sharing amounts.** Because of this, it is very important to help to keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number

- Changes in any other medical or drug coverage you have (such as from your group sponsor, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If your designated responsible party, such as a caregiver, changes

If any of this information changes, 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. Call Social Security at **1-800-772-1213,** TTY users call **1-800-325-0778** .

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have in addition to this retiree drug coverage. We can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits.**

Once a year, we'll send you a letter that lists any other medical and or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that is not listed, call Member Services. You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance, Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the primary payer), pays up to the limits of its coverage. The insurance that pays second, (the secondary payer), only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

Your retiree prescription drug coverage has two parts: a Medicare Part D plan and Senior Rx Plus, a non-Medicare prescription drug plan. Together, these plans determine how much you pay. Your copayment or coinsurance amounts after both plan benefits have been applied are shown in the Benefits Chart at the front of this document. For covered drugs that are eligible under Medicare Part D, your Medicare Part D plan pays first, and Senior Rx Plus pays second. If your plan covers drugs that are not covered by Medicare Part D but are included under the Extra Covered Drugs benefit those are covered only by the Senior Rx Plus plan.
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) are 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 has more than 100 employees.
  - If you're over 65 and (you or your spouse or domestic partner) are 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 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:

Phone numbers and resources

SECTION 1 Your plan contacts

How to contact our plan's Member Services
For help with claims, billing, or member card questions, call or write to Member Services. We'll be happy to help you.

	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 Pharmacy 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 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	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**

	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 ask for a coverage decision or appeal about your Part D prescription drugs

A coverage decision is a decision we make about your coverage or about the amount we pay for your Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your Part D prescription drugs, see Chapter 7.

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.

	Coverage Decisions – Contact Information
Call	**1-833-285-4636** Calls to this number are free. 24 hours a day, 7 days a week Pharmacy 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 hearing or speaking. Calls to this number are free.
Fax	**1-844-521-6938**
Write	Anthem Blue Cross Attention: Pharmacy Department P.O. Box 47686 San Antonio, TX 78265-8686
Website	**www.anthem.com/ca**

Method	Appeals – Contact Information
Call	**1-833-285-4636** Calls to this number are free. 24 hours a day, 7 days a week Pharmacy 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 hearing or speaking. Calls to this number are free.
Fax	**1-888-458-1407**
Write	Anthem Blue Cross Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Website	**www.anthem.com/ca**

How to make 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 doesn't involve coverage or payment disputes. For more information on how to make a complaint about your Part D prescription drugs, go to Chapter 7.

	Complaints – Contact Information
Call	**1-833-285-4636** Calls to this number are free. 24 hours a day, 7 days a week Pharmacy 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 hearing or speaking. Calls to this number are free.
Fax	**1-888-458-1407**

	Complaints – Contact Information
Write	Anthem Blue Cross Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Medicare Website	To submit a complaint about your plan directly to Medicare, go to **www.Medicare.gov/my/medicare-complaint**.

How to ask us to pay our share of the cost of a drug you got

If you got a bill or paid for drugs (like a pharmacy bill) you think we should pay for, you may need to ask our plan for reimbursement or to pay the pharmacy bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7, for more information.

	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 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 Get help from Medicare

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 (CMS). This agency contracts with Medicare prescription drug plans, including our plan.

	Medicare – Contact Information
Call	**1-800-MEDICARE**, (**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 hearing or speaking. Calls to this number are free.
Chat Live	Chat Live at **Medicare.gov/talk-to-someone**
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	**www.Medicare.gov** • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly Wellness visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit **www.Medicare.gov** to tell Medicare about any complaints you have about your plan. **To submit a complaint to Medicare**, go to **www.Medicare.gov/my/medicare-complaint**.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. SHIP is an independent state program (not connected with any insurance company or health plan) 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, make complaints about your medical care or treatment, and straighten out problems, with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices and answer questions about switching plans.

Method to Access SHIP and Other Resources:
• Visit **https://www.shiphelp.org** (Click on SHIP LOCATOR in middle of page) • Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

For contact information, 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 (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare 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's not connected with our plan.

Contact the QIO if you have a complaint about the quality of care you have got. 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, 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 determines Medicare eligibility and handles Medicare enrollment.

Social Security is also responsible for determining who has to pay an extra amount for 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, contact Social Security to let them know.

	Social Security – Contact Information
Call	**1-800-772-1213** Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday. 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 hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 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.

Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **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.

To find out more about Medicaid and Medicare Savings Programs, please refer to the state-specific agency listing, which is located in the Medicaid section of Chapter 11 in this document.

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (**www.Medicare.gov/basics/costs/help/drug-costs**) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible and copayments and coinsurance. Extra Help also counts toward your out- of-pocket costs.

If you automatically qualify for Extra Help Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply any time. To see if you qualify for getting Extra Help:

- Visit **https://secure.ssa.gov/i020/start** to apply online.
- Call Social Security at Social Security at **1-800-772-1213,** TTY users call **1-800-325-0778**; or

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call 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 it's rules. Phone numbers are located in Chapter 11. Or call **1-800-MEDICARE** (**1-800-633-4227**), and say Medicaid for more information. TTY users call **1-877-486-2048**. You can also visit **www.Medicare.gov** for more information.

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

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

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

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost sharing help.

Note: To be eligible for the ADAP in your state, people 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, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call your state ADAP.

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

State Pharmaceutical Assistance Programs (SPAP)

Many states have State Pharmaceutical Assistance Programs (SPAP) that help 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, refer to the state-specific agency listing, which is located in the SPAP section of Chapter 11 in this document.

SECTION 8 Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your Part D prescription costs, for drugs covered by our plan by spreading them across **the calendar year** (January – December). **Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option.** This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. This program does not apply to Part B drugs or Extra Covered Drugs if your plan includes these benefits.

If you're participating in the Medicare Prescription Payment Plan and stay in **the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this payment option, call or visit **Medicare.gov**.

	The Medicare Prescription Payment Plan – Election Support
Call	**1-833-246-7717** Calls to this number are free. Monday through Friday, 8 a.m. to 8 p.m. EST Member Services also has free language interpreter services for non-English speakers.
TTY	**711** Calls to this number are free. Monday through Friday, 8 a.m. to 8 p.m. EST This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

	The Medicare Prescription Payment Plan – Election Support
Fax	**1-440-557-6525**
Write	SimplicityRx Mailstop: 1004 MPPP Election Dept. 13900 N. Harvey Ave Edmond, OK 73013
Website	**www.Activate.RxPayments.com**

SECTION 9 Railroad Retirement Board (RRB)

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 get your Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

	Railroad Retirement Board (RRB) – Contact Information
Call	**1-877-772-5772** Calls to this number are free. Press "0", to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1", to access the automated RRB HelpLine and get 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 hearing or speaking. Calls to this number aren't free.
Website	**https://RRB.gov/**

SECTION 10 If you have group insurance or other health insurance from another group sponsor

If you have group insurance from another group sponsor, 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 call **1-877-486-2048**. with questions related to your Medicare coverage under this plan.

CHAPTER 3:

Using our plan for Part D drugs

SECTION 1 Basic rules for our plan's Part D drug coverage

In addition to your coverage for Part D drugs through our 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, go to your Medicare & You 2027 handbook.) Your Part D prescription drugs are covered under our plan.

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

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription that's 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 (Go to Section 2), or you can fill your prescription through our plan’s mail-order service.
- 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.
- 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 references. (Go to Section 3.1 for more information about a medically accepted indication).
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

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

In most cases, your prescriptions are covered only if they're filled at our plan’s network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with us to provide your covered drugs. The term covered drugs means certain Part D eligible drugs. It also means Extra Covered Drugs if shown in the Benefits Chart located at the front of this document.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to 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.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy 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 our website at **www.anthem.com/ca**.

Specialized pharmacies

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 difficulty getting Part D drugs in an LTC facility, call 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 your network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your Pharmacy Directory or call Pharmacy Member Services.

Section 2.2 Our plan's mail-order service

Our plan's mail-order service allows you to order **up to a 90-day supply for most drugs.**

Specialty drugs are generally limited to a 30-day supply on most plans. Refer to the Benefits Chart at the front of this document to confirm your plan's limit. Specialty drugs are high-cost medications that require special handling and are dispensed by specialty pharmacies. While specialty pharmacies may ship medications by mail, they are not considered mail-order pharmacies. As a result, most specialty drugs are not eligible for mail-order cost-sharing and will be subject to the specialty tier cost-share.

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 don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Pharmacy Member Services.
- If you 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. It's important you respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office contact us by calling Pharmacy Member Services.

- 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 get a prescription automatically by mail that you do not want, and you weren't 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, call 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 get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 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 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. Your Pharmacy Directory tells you 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 can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Check the Benefits Chart located at the front of this document to find out what your costs will be for a long-term supply of maintenance drugs using either option.

Section 2.4 Using a pharmacy that's not in the plan's network

Generally, we cover drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy.

Check first with Pharmacy Member Services to see if there's a network pharmacy nearby.

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

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

Additionally, the pharmacy isn't located outside the United States or its territories.

If you must use an out-of-network pharmacy, you'll 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. (Go to Chapter 5, Section 2 for more information on how to ask our plan to pay you back). You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy

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 our plan's Drug List

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

Our plan has a List of Covered Drugs (formulary). In this Evidence of Coverage, **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

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

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

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 Drug List (formulary) groups the plan's covered drugs in categories based on the specific medical conditions that are approved to treat.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives 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 available for many brand name drugs and biosimilar alternatives for some biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 10 for definitions of types of drugs that may be on the Drug List.

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 7.)

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

Every drug on our plan's Drug List is in one of your plan's cost sharing tiers. In general, the higher the 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're covered in a lower tier; however, some more expensive generic drugs may be on a higher tier.

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

The amount you pay for drugs in each cost sharing tier is also shown in the Benefits Charts located at the front of this document.

Section 3.3 How to find out if a specific drug is on your Drug List

To find out if a drug is on our Drug List, you have these options:

1. Visit our 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 our plan's Drug List or to ask for a copy of the list.
3. Use our plan's Price a Medication Tool **www.anthem.com/ca** to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition.

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and our 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.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once on 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 example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Pharmacy Member Services to learn what you or your provider can to do to get coverage for the drug. **If you want us to waive the restriction for you, you 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. (Go to Chapter 7).

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 our health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from us based on specific criteria before we 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 don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our 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's 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 you can do if one of your drugs isn't covered the way you'd like

There are situations where there's a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but it's in a cost sharing tier that makes your cost sharing more expensive than you think it should be.
- **If your drug is in a cost sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.**

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

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug that you're already taking. This temporary supply gives you time to talk with your provider about the change.

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

- **If you're a new member**, we'll cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in our plan last year**, we'll 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 our prescription is written for fewer days, we'll 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. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days, and live in a long-term care facility and need a supply right away:**

  We'll 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're using a temporary supply of a drug, you should talk with our provider to decide what to do when your temporary supply runs out. You have two options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. 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.

Option 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'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask us to cover a drug even though it is not on our plan's Drug List. Or you can ask our 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 set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to 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. 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 our plan to make an exception in the cost sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 7, Section 5.4 for what to do. It explains the procedures and deadlines 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.

You're also not eligible for a tiering exception when there isn't a lower-tier brand name drug available for the same use. For example, if you request a tiering exception for a brand name drug that's already on the lowest brand tier—but generic alternatives exist—we can't reduce your cost share to the generic tier.

SECTION 6 Our Drug List can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to your Drug List. You will receive notice when necessary. For example, our 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.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

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're taking. Notice may be sent after the change has been made.

Changes to the drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
    - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.

- We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
- We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you with information about the specific change we made.

- **Removing 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 take that drug, we'll tell you after we make the change.

- **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.

- **Making 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, based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional one-month's supply of the drug you're taking.
  - If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you including changing to a different drug to treat your condition or ask for a coverage decision to satisfy any new restrictions on the drug you're taking.
  - You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you've been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 7.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're 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 won't 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 take (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), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll 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 drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we do not cover

Some kinds of prescription drugs are excluded. This means Medicare doesn't 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'll 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 won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan usually can't cover off-label use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. Off-label use is any use of the drug other than those indicated on a drug's label as approved by the FDA.
- Our 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 Senior Rx Plus plan covers them as Extra Covered Drugs. 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 requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you have coverage for some prescription drugs (enhanced drug coverage) 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 doesn't count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 6.)

If you get Extra Help to pay for your prescriptions, the Extra Help program won't pay for drugs not normally covered. Refer to the plan's Drug List or call Pharmacy Member Services for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. For contact information, refer to the state-specific agency listing located in Chapter 11.

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your ID card), at the network pharmacy you choose. The network pharmacy will automatically bill our plan for our share of your drug cost. You need to pay the pharmacy your share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call us to get the information.

If the pharmacy can't 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. Go to Chapter 5, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

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

Section 9.2 As 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 uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or one that it uses, as long as it's part of our network.

Check your Pharmacy Directory to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Pharmacy Member Services. If you're in an LTC facility, we must ensure that you are able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way?

Go to for Section 5 more information about getting 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're enrolled in our plan. 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. 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 If you have a Medigap (Medicare Supplement Insurance) policy with 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 enrolled in this Part D plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

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

Section 9.5 If you also have drug coverage from another retiree group-sponsored plan

If you have other drug coverage from another retiree group, contact **that group's sponsor**. They can help you understand how your current drug coverage will work with our plan.

Section 9.6 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication, or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get 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 getting 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

We may conduct drug use reviews to help make sure our members get safe and appropriate care.

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of our age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you're taking
- Unsafe amounts of opioid pain medications

If we see a possible problem within your use of medications, we'll work with your provider to correct the problem.

Section 10.1 Drug Management Program (DMP) to help members safely use 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 prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid medications may not be 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 prescriber(s)
- Limiting the amount of opioid medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll also have an opportunity to tell us which prescribers 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'll 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'll review your case and give you a decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 7 for information about how to ask for an appeal.

You won't be placed on our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) and other programs to help members manage 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 our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, 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 get 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. 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'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about these programs, call Member Services.

CHAPTER 4:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're 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'll 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, call Member Services and ask for the LIS Rider. Phone numbers for Member Services are printed on the back cover of this document.

We use drug in this chapter to mean a Part D prescription drug. 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 Senior Rx Plus supplemental benefits include 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, explains these rules. When you use our plan's Price a Medication Tool to look up drug coverage, the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the Price a Medication Tool by calling Pharmacy Member Services.

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** (if your plan has one) is the amount you pay for drugs before our plan starts to pay our 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 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't 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 covered drugs and you followed the rules for drug coverage explained in Chapter 3):

- The amount you pay for drugs when you're in 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 drug plan before you joined our plan.
- Any payments for your drugs made by family or friends.
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs) and most charities.

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have reached the CMS defined drug out-of-pocket limit, within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs don't include any of these types of payments:

- Your monthly premium, if applicable.
- Drugs you buy outside the United States and its territories.
- Drugs that aren't covered by our plan.
- Drugs you get at an out-of-network pharmacy that don't meet our 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 not normally covered in a Medicare Drug Plan.
- Payments for your drugs made by certain insurance plans and government funded health programs such as TRICARE and the Veterans Health Administration (VA).
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).
- Payments made by drug manufacturers under the Manufacturer Discount Program.

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services.

Tracking your out-of-pocket total costs

- The Part D Explanation of Benefits (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches the CMS defined drug out-of-pocket limit shown in your benefit chart, the Parts D EOB will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.

- Make sure we have the information we need. Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stage for plan members

There are 3 drug payment stages that may be used in your plan. The drug payment stages used in your plan are shown in the Benefits Chart located at the front of this document. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained on 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: Catastrophic Coverage Stage

SECTION 3 Your Part D Explanation of Benefits (EOB) explains and which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-pocket cost:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs). If your plan includes coverage for Extra Covered Drugs any payments made for these drugs will not be included in your out-of-pocket cost because these are not Part D eligible drugs.
- **Total drug costs:** this is the total of all payments made for our covered Part D drugs. It includes what our plan paid what you paid and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month we'll send you a Part D Explanation of Benefits (Part D EOB). The Part D EOB includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our Group Part D and Senior Rx Plus coverage paid, and what you and others paid on your behalf.
- **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 shows the total drug costs and total payments for our drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 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's how you can help us keep your information correct and up to date:

- **Show your ID card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **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 won't 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 your receipts.

  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 use a discount card that's not part of your plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies, or pay the full price for a covered drug under special circumstances.
  - If you're 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 make for you**. Payments made by certain other people 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 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 get 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 questions, call Member Services. Be sure to keep these reports.

SECTION 4 The Deductible Stage

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, it does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.

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 The Initial Coverage Stage

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

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

Our plan has cost sharing tiers

Every drug on our 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, see the Benefits Chart located at the front of this document.

To find out which cost sharing tier your drug is in, 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 isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 3, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

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

Section 5.2 When does the Initial Coverage Stage end?

You stay in the Initial Coverage Stage until you reach the CMS defined drug out-of-pocket limit which can be found in the Benefits Chart located at the front of this document. You then move to the Catastrophic Coverage Stage.

If we offer additional coverage on some prescription drugs that aren't normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won't count towards the CMS defined drug out-of-pocket costs.

The Part D EOB that you get will help you keep track of how much you, our plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the CMS defined drug out-of-pocket limit in a year.

We'll let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.2 on how Medicare calculates your 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 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're trying a medication for the first time). You can also ask your doctor to prescribe, and our pharmacist to dispense, less than a full month's supply of your drugs, if this will help you plan refill dates better.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're 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, our cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you will only pay for the number of days of the drug that you get instead of a whole month. We 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 get.

SECTION 6 In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs

In the Catastrophic Coverage Stage you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the CMS defined out-of-pocket limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this coverage stage until the end of the calendar year.

During this stage, you pay nothing for your covered Part D drugs. If your plan includes coverage for Extra Covered Drugs, you may continue to pay a copay or coinsurance.

SECTION 7 Additional benefits information

Your Senior Rx Plus coverage may include the Extra Covered Drugs benefit. Payments made for these drugs will not count toward the CMS defined drug out-of-pocket 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 8 What you pay for Part D vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List Our plan covers most Part D vaccines at no cost to you. Refer to our plan's Drug List or call Member Services for coverage and cost sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

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

Your costs for a Part D vaccine depends on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
    - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
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 or another provider may give the vaccine in the pharmacy or, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what drug payment stage you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times, when you get the vaccine, you pay only your share of the cost under our Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1:

You get the Part D vaccine at the network pharmacy. Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you 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 vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine and the cost for the provider to give it to you.
- You can then ask our plan to pay its share of the cost, by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration) and less any difference between the amount the doctor charges and what we normally pay. If you get Extra Help, we'll reimburse you for this difference.

Situation 3:

You buy the Part D vaccine itself at the network pharmacy, and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you have to pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to 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.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid.
- You'll 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'll reimburse you for this difference.

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

When billing us for a vaccine, 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, call Member Services.

CHAPTER 5:

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

SECTION 1 Situations when you should ask us to pay our share for covered drugs

Sometimes when you get a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). Its your right to be paid back by our plan whenever you've paid more than your share of the cost for drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got.

1. **When you use an out-of-network pharmacy to fill a prescription**
   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 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. Go to Chapter 3, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

2. **When you pay the full cost for a prescription because you don't have our ID card with you**
   If you don't have our ID card with you, you can ask the pharmacy to call our plan or look up your enrollment information. However, if the pharmacy can't 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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 the drug isn't covered for some reason.

   For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction 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 to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

4. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our 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'll need to submit paperwork for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the drug should be covered. This is called making a coverage decision. If we decide it should be covered, we'll pay our share of the cost for the drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

You can ask 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 got the drug.

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

- You don't have to use the form, but it'll help us process the information faster.
- 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'll consider your request for payment and say yes or no

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

- If we decide the drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the drug we'll mail your reimbursement of our share of the cost to you.
- If we decide the drug is not covered, or you did not follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you we won't pay for all or part of the drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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, etc)

Our 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 our plan may meet these accessibility requirements include, but aren't limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's 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 our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services. You can 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 you get timely access to 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 you aren't 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're 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 don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information, including information about your Part D 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's been shared with others

You have the right to look at your medical records held at our plan, and to get a copy of your records. We're 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'll 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services.

Protecting your personal health information is important. Each 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 three of these required yearly communications:

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

Would you like to go paperless and read this online or on your mobile app? Go to **www.anthem.com/ca** and sign up to get these notices by email.

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 ID card for more details.

Your personal information

Your nonpublic (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 MEDICAL, VISION, AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. 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 healthcare 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 PHI with technology to support and enable services provided to you
- 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
- Responding to the Secretary of Human and Health Services for HIPAA rules compliance and enforcement purposes

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, disability status, sexual orientation, and gender identity: We may collect, infer, receive and/or maintain race, ethnicity, language, disability status, 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, disability status, 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.

Please note Elevance Health and its subsidiaries comply with Executive Order 14168.

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 ID 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 information 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. One example is with Substance Use Disorder (SUD) Information we may receive from Providers or programs regulated by federal law (42 CFR Part 2). All disclosures of such SUD information must comply with applicable Federal and State privacy laws, including 42 CFR Part 2. We are allowed to Use and Disclose SUD information for certain Treatment, Payment, and Health Care Operations activities. You have the right to consent to the

disclosure of SUD information in certain circumstances. You can revoke this consent in writing at any time.

Your Part 2 SUD records (or someone's testimony about what those records say) cannot be used or shared in a case against you in civil, criminal, administrative, or legislative proceedings unless:

- You give written permission, or
- A court orders the disclosure and the order is accompanied by a subpoena or similar legal requirement, and you (or the person holding your SUD records) are given notice and a chance to speak to the court before the records are shared.

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 ID card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting **https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**. 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 ID 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. The most recent revision is noted in the footer at the end of this document. You can request the current version from Member Services at the phone number printed on your ID 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
- Request correction if the consumer believes the information to be inaccurate
- Add a rebuttal statement to the file if there is a dispute
- Know the reasons for an adverse underwriting decision
- With very narrow exceptions, the right not be subjected to pretext interviews.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently based on race, color, national origin, sex, age, or disability. If you have disabilities, we offer free aids and services. If your main language isn't English, we offer help for free through interpreters and other written languages. Call the Member Services number on your ID card for help (TTY/TDD: **711**).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint through one of these ways:

- Write to Compliance Coordinator, **P.O. Box 27401, Mail Drop VA2002-N160 Richmond, VA 23279**.
- File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at **200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201**.
- Call **1-800-368-1019,** (TDD: **1-800-537-7697**).
- Go online at **https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf** and fill out a complaint form at **https://www.hhs.gov/ocr/complaints/index.html**.

Get help in your language

One more right that you have is to get this information in your language for free. If you'd like extra help to understand this in another language, call the Member Services number on your ID card (TTY/TDD: **711**).

Aside from helping you understand your privacy rights in another language, we also offer this notice in a different format for members with visual impairments. If you need a different format, please call the Member Services number on your ID card.

Section 1.4 We must give you information about our plan, our network of pharmacies, and your covered drugs

As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, 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 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 isn't 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 You have the right to know your treatment options and participate in decisions about your care

You have the right to give instructions about what's to be done if you can't 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're in this situation. This means, 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.

Legal documents you can use to give directions in advance in these situations are called **advance directives.** Documents like **living will** and **power of attorney for health care** are examples of advance directives.

How to set an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, from a social worker or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.

- **Give copies of the form to the right people.** 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're going to be hospitalized, and you 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 didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the appropriate state-specific agency. For contact information, refer to the state-specific agency listing located in Chapter 11.

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

If you have any problems, concerns, or complaints and need to ask for 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're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019,** TTY users call **1-800-537-7697** or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- Call **Member Services**.
- Call your local **SHIP**. For contact information, refer to the state-specific agency listing located in Chapter 11.
- **Call Medicare** at **1-800-MEDICARE (1-800-633-4227)**, TTY users call **1-877-486-2048**.

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- Call **Member Services**.
- Call your local **SHIP**. For contact information, refer to the state-specific agency listing located in Chapter 11.
- Call **Medicare**.
  - Visit **www.Medicare.gov** to read the publication Medicare Rights & Protections available at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.
  - Call **1-800-MEDICARE** (**1-800-633-4227**); (TTY **1-877-486-2048**)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, 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's covered and the rules you need to follow to get our covered drugs.
  - Chapters 3 and 4 give details about Part D drug coverage.
- **If you have any other drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you're enrolled in our plan.** Show our ID card whenever you get your Part D 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 you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Pay what you owe.** As a plan member, you're 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 our plan, you must pay your share of the cost when you get the drug.
  - If you're required to pay a late enrollment penalty, you must pay the penalty to stay a member of our plan.
  - If you're 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 stay a member of our plan.

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

CHAPTER 7:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

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. Call Member Services. We'll 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 2 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 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 information in this chapter will help you identify the right process to use and what to do.

Section 1.1 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. To make things easier, this chapter uses more familiar words in place of some legal terms:

However, it's sometimes important 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 these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services for help. In some situations you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

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're having. They can also answer questions, give you more information, and offer guidance on what to do.

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

Medicare

You can also contact Medicare for help:

- Call **1-800-MEDICARE** (**1-800-633-4227**), TTY users call **1-877-486-2048**.
- Visit **www.Medicare.gov**.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to, **Section 4, A guide to coverage decisions and appeals.**

No.

Go to, **Section 7, 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 coverage decisions and appeals

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 before you get benefits

If you want to know if we'll cover a specific drug before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll 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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide a drug isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision whether before or after you get a benefit, and you aren't satisfied, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage

decision we made. Under certain circumstances, you can ask for 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 properly followed the rules. When we complete 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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we don't dismiss your case but say no to all or part of your Level 1 appeal, you can go on to 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 (This chapter explains Level 3, 4, and 5 appeals).

Section 4.1 Get help 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:

- **Call Member Services**.
- **Get free help from** your State Health Insurance Assistance Program. For contact information, refer to the state-specific agency listing located in Chapter 11.
- **Your doctor or other prescriber can make a request for you**. If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services and ask for the Appointment of Representative form. (The form is also available at **www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.)
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** 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 at **www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request form or an equivalent written notice from a representative, we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll 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 can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

Section 5.1 What to do if you have problems getting a Part D drug or 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. (Go to Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to 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 don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover them.
- If your pharmacy tells you that your prescription can't 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'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on your plan's Drug List. **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 prior authorization criteria, or the requirement to try another drug first). **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 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 Asking for an exception

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

If a drug isn't covered in the way you'd 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 3 examples of exceptions that you, your doctor, or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our plan's Drug List.**
    - If we agree to cover a drug not on your Drug List, you'll need to pay the cost sharing amount that applies to drugs in the non-preferred drug tier. You can't ask for an exception to the cost sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug List.
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 cost-sharing 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 Medical Benefits Chart located at the front of this document. In general, the lower the cost sharing tier number, the less you pay as your share of the cost of the drug.
    - If our Drug List contains an alternative drug(s) for treating your medical condition that is 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 biological product you can ask us to cover your drug at a lower cost sharing amount. This would be the lowest tier cost that contains biological product 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 can't 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's more than one lower cost-sharing tier with alternative drugs you can't take, you 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 you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically 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're askng for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally won't 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 our 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 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 get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a drug you didn't get. (You can't 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 regain function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll 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 asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the prescription 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 help us process your request, include your name, contact information, and information that shows 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're asking for 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 get your request.
  - For exceptions, we'll give you our answer within **24 hours** after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 24 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.

- If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.

- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to provide **within 72** hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you've already purchased

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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're going to Level 1 of the appeals process.

Section 5.5 How to make a Level 1 appeal

LEGAL TERMS	An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is 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 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you're appealing a decision we made about a drug, 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 Redetermination Request Form. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 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 asking for 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 give you our answer.

- When we review your appeal, we take another careful look at all 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 get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll 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 get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 5.6 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for, we must provide the coverage** as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll 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 already bought

- We must give you our answer **within 14 calendar days** after we get your request.
    - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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 How to make a Level 2 appeal

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

The **independent review organization is an independent organization hired by Medicare**. It isn't 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 independent review organization. You must make your appeal request within 65 calendar days from the date on the written notice.
- If we did not complete our review within the applicable timeframe, or made an unfavorable decision regarding an at-risk determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information we have about your appeal to the independent review 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 about your appeal.

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

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

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent 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 independent review organization **within 72 hours** after we get the decision from the independent 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're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent 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's also called turning down your appeal. In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Let you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking meets a certain minimum. If the dollar value of the drug coverage you're asking is too low, you can't make another appeal and the decision at Level 2 is final.

- Tells 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 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go to a Level 3 appeal 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 explains the Levels 3, 4, and 5 appeals process.

SECTION 6 Taking your appeal to Level 3, 4 and 5

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

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the drug you appealed meets certain minimum levels, you may be able to go to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's 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 get the decision.

- If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don’t 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 a Level 4 appeal.

If the answer is no, the appeals process may or may not be over.

- If you decide to accept the decision that turns down your appeal, the appeals process is over.
- If you don't 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 a 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 get the decision
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
    - If you decide to accept the decision that turns down our appeal, the appeals process is over.
    - If you don't 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, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

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

- A judge will review all 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 about quality of care, waiting times, and member service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you have got?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?

Complaint	Example
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're being encouraged to leave our plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Member Services or other staff at our 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 about the timeliness of our actions related to coverage decisions and appeals)	If you asked us for a coverage decision or made an appeal, and you think we aren't 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 said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't 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 called **filing a grievance**.
- **Using the process for complaints** is called **using the process for filing a grievance**.
- A **fast complaint** is called an **expedited grievance**.

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

- **Calling Member Services is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call, or you called and weren't satisfied, you can put your complaint in writing and send it to us**. If you put your complaint in writing, we'll 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'll 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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don’t take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 7.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about quality of care, you have 2 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 7.4 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/my/medicare-complaint**. You can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

CHAPTER 8:

Ending your membership in our plan

SECTION 1 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 decide you want to leave. Section 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your prescription drugs and you'll 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, contact your group sponsor.

Note: If you disenroll from Medicare drug coverage and go without creditable 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 drug coverage. Go to Chapter 1, Section 4.3 for more information about the late enrollment penalty.

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

You can end your membership in our plan during the Open Enrollment Period each year. During this time, review your health and drug coverage and decide on coverage for the upcoming year.

- **The Open 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 coverage:
  - An Individual (non-group) Medicare drug plan
  - Original Medicare with a separate Medicare drug plan.

- Original Medicare without a separate Medicare drug plan.
  - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.
- 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 the Medicare Part A (hospital) and Part B (medical) benefits. Most 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, call 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 group sponsored membership will end in our plan** when your new plan's coverage begins.
- **Note:** If you disenroll from Medicare drug coverage and go without creditable 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. This typically occurs 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.

Check with your group sponsor 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 our plan, call Medicare, or visit the **www.Medicare.gov**:
  - Usually, when you move.
  - If you have Medicaid.
  - If you're eligible for Extra Help paying for Medicare prescriptions.
  - If we violate our contract with you.
  - If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

- If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE isn't available in all states. If you would like to know if PACE is available in your state, contact Member Services.

- **Enrollment time periods vary** depending on your situation.
- **To find out if you're eligible for a Special Enrollment Period**, call **Medicare** at **1-800-MEDICARE (1-800-633-4227),**TTY users call **1-877-486-2048**. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:
  - An Individual (non-group) Medicare drug plan.
  - Original Medicare without a separate Medicare drug plan.
  - 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 Medicare Part A (hospital) and Part B (medical) benefits. Some Medicare health plans also include Part D drug coverage.
    Note: If you disenroll from Medicare 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.
- **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, call 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 usually end** on the first of the month after we get your request to change plans or the date you request we terminate coverage on this plan, whichever is later.
- If you get Extra Help from Medicare to pay your drugs coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.3 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- Contact your group sponsor to get information on options available to you.
- Call **Member Services**.
- Find the information in the **Medicare & You 2027** handbook.
- Contact **Medicare** at **1-800-MEDICARE** (**1-800-633-4227**), TTY users call **1-877-486-2048**.

SECTION 3 How to 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, call your group sponsor.

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

To switch from our plan to:	Here's what to do:
An Individual (non-group) Medicare prescription drug plan.	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from your group-sponsored plan when your new plan's coverage starts.
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 drug plan or call 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)**, and ask to be disenrolled. TTY users call **1-877-486-2048**.
Original Medicare without a separate Medicare drug plan.	• **Send us a written request to disenroll**. Call Member Services if you need more information on how to do this. • You can also call Medicare at **1-800-MEDICARE (1-800-633-4227)**, and ask to be disenrolled. TTY users call **1-877-486-2048**. • You'll be disenrolled from your group-sponsored plan when your coverage in Original Medicare starts.

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

Until your membership ends, and your new Medicare coverage starts, 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 our plan membership in certain situations

We must end your membership in our 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're 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're no longer a United States citizen or national, or an eligible noncitizen.
- 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're enrolling in our plan and that information affects your eligibility for our plan. We can't make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide care for you and other members of our plan. We can't make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your ID card to get prescription drugs. We can't 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're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose prescription drug coverage.
- If your group notifies us that they're 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.

If you have questions or want more information on when we can end your membership, call Member Services .

Section 5.1 We can't 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're 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**).

Section 5.2 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, (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 aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

Discrimination is against the law. That's why we comply with applicable Federal civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

For people with disabilities, we provide free aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

For people whose primary language is not English, we offer free language assistance services, which may include:

- Qualified interpreters
- Information written in other languages

If you need these services, call the phone number on your member ID card for help.

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to:

Compliance Coordinator
4361 Irwin Simpson Rd
Mailstop: OH0205-A537
Mason, Ohio 45040-9498

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

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

1-800-368-1019, TTY: **1-800-537-7697**

Complaint forms are available at **www.HHS.gov/ocr/index.html**.

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, as applicable, 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 Medical 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

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 got. For example, you may ask for an appeal if your plan doesn't pay for a drug you think you should be able to get. Chapter 7 explains appeals, including the process involved in making an appeal.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to **Original Biological Product** and **Biosimilar**).

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective, as the original biological product. Some biosimilars are substituted for the original biological product at the pharmacy without needing a new prescription. (Go to Interchangeable Biosimilar).

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 that begins when you (or other qualified parties on your behalf), have paid the CMS defined drug out-of-pocket limit for Part D covered drugs during the covered year. You can find our out of pocket amount listed on the Benefits Chart at the front of this document. During this payment stage, our plan pays the full cost for your covered Part D drugs. If your plan includes coverage for Extra Covered Drugs, you may continue to pay a cost-share.

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 MA eligible people who have specific severe and chronic diseases.

CMS Defined Drug Out-of-Pocket Limit – The maximum amount you pay out of pocket for Part D drugs. If our plan includes coverage for Extra Covered Drugs any payments made for these drugs will not be included in our out-of-pocket costs because these are not Part D eligible drugs.

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 your deductible .

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 about quality of care, waiting times, and the member service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

Cost Sharing – If applicable, cost sharing refers to amounts that a member has to pay when drugs are received. It includes any combination of the following 3 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 our plan and the amount, if any, you're 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 our 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 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 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're 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 our plan is 30 days, then your daily cost sharing rate is $1 per day.

Deductible – If applicable, 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 people 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 person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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're 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 isn't on our Formulary (a formulary exception), or get a non-preferred drug the lower cost sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction or if our plan limits the quantity or dosage of the drug you're asking for (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 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 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 doesn't 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 won't pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket cost total drug costs for the year have reached CMS defined drug out of pocket limit.

Initial Enrollment Period – When you're 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.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

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 FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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 i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a 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-Covered Services – Services covered by Medicare Part A and Part B. The term Medicare-Covered Services doesn't 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 our 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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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.

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-Preferred 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 drugs can offer. If your plan covers both preferred and non-preferred drugs, the non-preferred drugs usually cost you more. If your plan does not cover non-preferred drugs, and your physician feels that you should take the non-preferred drug, you may request an exception. Go to Chapter 7, Section 5.2 for how to request an exception.

Open Enrollment Period — A set period of time determined by the client, a retiree is eligible to elect to enroll or make changes to their current enrollment in a Medicare Advantage, Medicare Advantage/Prescription Drug or Prescription Drug plan offered by their former employer. If the retiree does not enroll in a Medicare Advantage plan at that time, they will remain in Original Medicare or their current plan. In some instances, a special enrollment period may be available to individuals to elect an Individual plan.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – Go to 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 services and supports (LTSS) 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 get both their Medicare and Medicaid benefits through our plan. If you would like to know if PACE is available in your state, call Member Services.

Part C – Go to 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 plan 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're first eligible to join a Part D plan.

Preferred Drug – These are drugs that have been identified as excellent values both clinically and financially. Before a drug can be designated as a preferred 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 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 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.

Price a Medication Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Prior Authorization – Approval in advance to get certain drugs based on specific criteria. Covered drugs that need prior authorization are marked in the Formulary and our criteria are posted on our website.

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 a drug 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.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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 cost for Select Generics. If our plan includes a reduced cost, you can find this information listed on the Medical 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. Our plan may disenroll you if you permanently move out of our 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're 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 $950 or more per unit.

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'll 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 aren't 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 07/15/2026. For more recent information or other questions, call Member Services.

Alabama

Alabama Department of Senior services
201 Monroe Street Suite 350
Montgomery, AL 36104
1-800-243-5463, TTY: **711**
https://www.alabamaageline.gov/ship

Alaska

Alaska State Health Insurance Assistance Program (SHIP)
1835 Bragaw Street Suite 350
Anchorage, AK 99508
1-800-478-6065, TTY: **1-800-770-8973**
https://health.alaska.gov/en/

Arizona

Arizona State Health Insurance Assistance Program (SHIP)
1789 West Jefferson Site Code MD6288
Phoenix, AZ 85007
1-800-432-4040, TTY: **711**
https://des.az.gov/medicare-assistance

Arkansas

AR SHIIP
1 Commerce Way
Little Rock, AR 72202
1-800-224-6330, TTY: **1-800-224-6330**
https://insurance.arkansas.gov/consumer-assistance/medicare-resources/shiip/

California

California Health Insurance Counseling and Advocacy Program (HICAP)
2880 Gateway Oaks Drive Suite 200
Sacramento, CA 95833
1-800-434-0222, TTY: **1-800-735-2929**
https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/

Colorado

Colorado Senior Health Insurance Assistance Program (SHIP)
1560 Broadway Suite 850
Denver, CO 80202
1-888-696-7213, TTY: **711**
https://doi.colorado.gov/types-of-insurance/health-insurance/senior-health-care-medicare

Connecticut

Connecticuts program for Health insurance assistance, Outreach, Information and referral, Counseling, Eligibility Screening (CHOICES)
55 Farmington Avenue 12th Floor
Hartford, CT 06105
1-800-994-9422, TTY: **711**
https://portal.ct.gov/ads/programs-and-services/choices?language=en_US

Delaware

Delaware Medicare Assistance Bureau (DMAB)
1351 West North Street Suite 101
Dover, DE 19904
1-800-336-9500, TTY: **711**
https://insurance.delaware.gov/

District of Columbia

DC State Health Insurance Assistance Program (SHIP)
500 K Street NE
Washington, DC 20002
1-202-727-8370, TTY: **711**
https://dacl.dc.gov/

Florida

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**
https://www.floridashine.org/

Georgia

Georgia SHIP
47 Trinity Ave. S.W. Atlanta
GA 30334, GA 30334
1-866-552-4464, TTY: **711**
https://aging.georgia.gov/georgia-ship

Hawaii

Hawaii State Health Insurance Assistance Program (SHIP)
250 South Hotel Street Suite 406
Honolulu, HI 96813-2831
1-888-875-9229, TTY: **1-866-810-4379**
https://www.hawaiiship.org/

Idaho

Idaho Senior Health Insurance Benefits Advisors Program (SHIBA)
700 W. State Street P.O. Box 83720
Boise, ID 83720-0043
1-800-247-4422, TTY: **711**
https://doi.idaho.gov/shiba/

Illinois

Illinois Senior Health Insurance Program (SHIP)
One Natural Resources Way #100
Springfield, IL 62702-1271
1-800-252-8966, TTY: **711**
https://ilaging.illinois.gov/ship/aboutship.html

Indiana

State Health Insurance Assistance Program (SHIP)
311 W. Washington Street 2nd Floor
Indianapolis, IN 46204-2787
1-800-452-4800, TTY: **1-866-846-0139**
https://www.in.gov/ship/

Iowa

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**
https://shiip.iowa.gov/

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)
503 S. Kansas Ave
Topeka, KS 66603
1-800-860-5260, TTY: **711**
https://www.kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick

Kentucky

Kentucky State Health Insurance Assistance Program (SHIP)
275 East Main Street 3E-E
Frankfort, KY 40601
1-877-293-7447, TTY: **711**
https://chfs.ky.gov/agencies/dail/Pages/ship.aspx

Louisiana

Louisiana Senior Health Information Program (LaSHIP)
P.O. Box 94214
Baton Rouge, LA 70802
1-800-259-5300, TTY: **711**
https://www.ldi.la.gov/consumers/senior-health-shiip

Maine

Maine State Health Insurance Assistance Program (SHIP)
41 Anthony Ave.
Augusta, ME 04333
1-877-353-3771, TTY: **711**
https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance

Maryland

Maryland Department of Aging -Senior Health Insurance Assistance Program (SHIP)
36 S Charles St 12th Floor
Baltimore, MD 21201
1-800-243-3425, TTY: **711**
https://aging.maryland.gov/programs-and-services/medicare-support/state-health-insurance-assistance-program

Massachusetts

Massachusetts Serving the Health Insurance Needs of Everyone (SHINE)
One Ashburton Place 10th floor
Boston, MA 02108
1-800-243-4636, TTY: **1-877-610-0241**
https://www.mass.gov/orgs/executive-office-of-aging-independence-age

Michigan

Michigan Medicare/Medicaid Assistance Program (MMAP), Inc.
P.O. Box 30676
Lansing, MI 48909
1-800-803-7174, TTY: **1-888-263-5897**
https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/aging-services

Minnesota

Minnesota Aging Pathways
540 Cedar Street
St. Paul, MN 55164
1-800-333-2433, TTY: **1-800-627-3529**
https://mn.gov/aging-pathways/

Mississippi

Mississippi State Health Insurance Assistance Program (SHIP)
200 South Lamar St
Jackson, MS 39201
1-844-822-4622, TTY: **711**
https://www.mdhs.ms.gov/aging/finding-services-for-older-adults/

Missouri

Missouri State Health Insurance Assistance Program (SHIP)
601 W Nifong Blvd Suite 3A
Columbia, MO 65203
1-800-390-3330, TTY: **711**
https://www.missouriship.org/

Montana

Montana State Health Insurance Assistance Program (SHIP)
P.O. Box 4210 111 North Sanders Street
Helena, MT 59604
1-800-551-3191, TTY: **711**
https://dphhs.mt.gov/sltc/aging/ship

Nebraska

Nebraska State Health Insurance Assistance Program (SHIP)
PO Box 95087
Lincoln, NE 68509-5087
1-800-234-7119, TTY: **711**
https://doi.nebraska.gov/nebraska-ship-smp

Nevada

Nevada State Health Insurance Assistance Program (SHIP)
1550 College Parkway
Carson City, NV 89706
1-800-307-4444, TTY: **711**
https://www.adsd.nv.gov/programs/aging-services-medicare-assistance-program/

New Hampshire

New Hampshire ServiceLink Resource Centers
129 Pleasant Street
Concord, NH 03301
1-866-634-9412, TTY: **711**
https://www.dhhs.nh.gov/programs-services/adult-aging-care/aging-and-disability-resource-centers

New Jersey

New Jersey State Health Insurance Assistance Program (SHIP)
P.O. Box 715
Trenton, NJ 08625-0715
1-800-792-8820, TTY: **711**
https://www.nj.gov/humanservices/doas/services/q-z/ship/

New Mexico

New Mexico ADRC State Health Insurance Assistance Program (SHIP)
2550 Cerrillos Road
Santa Fe, NM 87505
1-800-432-2080, TTY: **1-505-476-4937**
https://www.aging.nm.gov/consumer-and-elder-rights/medicare/

New York

New York Health Insurance Information, Counseling and Assistance Program (HIICAP)
2 Empire State Plaza 5th Floor
Albany, NY 12223
1-800-701-0501, TTY: **711**
https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

North Carolina

North Carolina Seniors' Health Insurance Information Program (SHIIP)
1201 Mail Service Center
Raleigh, NC 27699-1201
1-855-408-1212, TTY: **711**
https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip/contact-seniors-health-insurance-information-program-shiip

North Dakota

North Dakota State Health Insurance Assistance Program (SHIP)
600 E Boulevard Ave
Bismarck, ND 58505-0320
1-888-575-6611, TTY: **1-800-366-6888**
https://www.insurance.nd.gov/consumers/medicare

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)
50 W. Town Street Suite 300
Columbus, OH 43215
1-800-686-1578, TTY: **1-614-644-3745**
https://insurance.ohio.gov/consumers/medicare/01-oshiip

Oklahoma

Oklahoma Medicare Assistance Program (MAP)
400 NE 50th Street
Oklahoma City, OK 73105
1-800-763-2828, TTY: **711**
https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/

Oregon

Oregon Senior Health Insurance Benefits Assistance (SHIBA)
350 Winter Street NE Room 330
Salem, OR 97309-0405
1-800-722-4134, TTY: **711**
https://shiba.oregon.gov/Pages/index.aspx

Pennsylvania

Pennsylvania Medicare Education and Decision Insight, PA MEDI
555 Walnut Street 5th Floor
Harrisburg, PA 17101-1919
1-800-783-7067, TTY: **711**
https://www.pa.gov/agencies/aging/aging-programs-and-services/pa-medi-medicare-counseling

Rhode Island

Rhode Island State Health Insurance Assistance Program (SHIP)
25 Howard Ave Building 57
Cranston, RI 02920
1-401-462-3000, TTY: **1-401-462-0740**
https://oha.ri.gov/Medicare

South Carolina

South Carolina Senior Health Insurance Assistance Program (SHIP)
1301 Gervais Street Suite 350
Columbia, SC 29201
1-800-868-9095, TTY: **711**
https://aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud

South Dakota

South Dakota Senior Health Information and Insurance Education (SHIINE)
3800 E. Hwy 34 500 East Capitol Avenue
Pierre, SD 57501
1-888-854-5321, TTY: **711**
https://dhs.sd.gov/en/ltss/shiine

Tennessee

Tennessee State Health Insurance Assistance Program (SHIP)
1104 England Drive 9th Floor
Cookeville, TN 38501
1-877-801-0044, TTY: **1-800-848-0299**
https://tnmedicarehelp.com/

Texas

Texas Department of Aging and Disability Services (HICAP)
701 West 51st Street MC: W275
Austin, TX 78711-3247
1-800-252-9240, TTY: **1-800-735-2989**
https://www.hhs.texas.gov/services/health/medicare

Utah

Utah Senior Health Insurance Information Program (SHIIP)
288 N. 1460 West
Salt Lake City, UT 84116
1-877-424-4640, TTY: **711**
https://daas.utah.gov/seniors/

Vermont

Vermont State Health Insurance Assistance Program
P.O. Box 73
Danville, VT 05828
1-800-642-5119, TTY: **711**
https://www.vermont4a.org/medicare-information

Virginia

VA Insurance Counseling & Assistance Program (VICAP)
5620 Cox Rd
Glen Allen, VA 23060
1-804-662-7000, TTY: **711**
https://dars.virginia.gov/aging/home-community/medicare-counseling/

Washington

Washington Statewide Health Insurance Benefits Advisors (SHIBA)
5000 Capitol Boulevard
Tumwater, WA 98504-0256
1-800-562-6900, TTY: **1-360-586-0241**
https://www.insurance.wa.gov/insurance-resources/medicare

West Virginia

West Virginia State Health Insurance Assistance Program (WV SHIP)
1900 Kanawha Blvd. East 3rd Floor Town Center Mall
Charleston, WV 25305
1-877-987-4463, TTY: **711**
http://www.wvship.org/

Wisconsin

Wisconsin State Health Insurance Assistance Program (Wisconsin SHIP)
1 West Wilson Street P.O. Box 7851
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 West Adams Ave
Riverton, WY 82501
1-800-856-4398, TTY: **711**
https://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program

SECTION 2 Quality Improvement Organization (QIO)

The following state agency information was updated on 07/15/2026. For more recent information or other questions, call Member Services.

Alabama

Acentra Health (Alabama's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, AL 32317
1-888-317-0751, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Alaska

Acentra Health (Alaska's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, AK 32317
1-888-305-6759, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Arizona

Commence Health (Arizona's Quality Improvement Organization)
PO Box 2687
Virginia Beach, AZ 23454
1-877-588-1123, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Arkansas

Acentra Health (Arkansas' Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, AR 32317
1-888-315-0636, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

California

Commence Health (California's Quality Improvement Organization)
PO Box 2687
Virginia Beach, CA 23454
1-877-588-1123, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Colorado

Acentra Health (Colorado's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, CO 32317
1-888-317-0891, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Connecticut

Acentra Health (Connecticut's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, CT 32317
1-888-319-8452, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Delaware

Commence Health (Delaware's Quality Improvement Organization)
PO Box 2687
Virginia Beach, DE 23454
1-888-396-4646, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

District of Columbia

Commence Health (District of Columbia's Quality Improvement Organization)
PO Box 2687
Virginia Beach, DC 23454
1-888-396-4646, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Florida

Acentra Health (Florida's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, FL 32317
1-888-317-0751, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Georgia

Acentra Health (Georgia's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, GA 32317
1-888-317-0751, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Hawaii

Commence Health (Hawaii's Quality Improvement Organization)
PO Box 2687
Virginia Beach, HI 23454
1-877-588-1123, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Idaho

Acentra Health (Idaho's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, ID 32317
1-888-305-6759, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Illinois

Commence Health (Illinois's Quality Improvement Organization)
PO Box 2687
Virginia Beach, IL 23454
1-888-524-9900, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Indiana

Commence Health (Indiana's Quality Improvement Organization)
PO Box 2687
Virginia Beach, IN 23454
1-888-524-9900, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Iowa

Commence Health (Iowa's Quality Improvement Organization)
PO Box 2687
Virginia Beach, IA 23454
1-888-755-5580, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Kansas

Commence Health (Kansas' Quality Improvement Organization)
PO Box 2687
Virginia Beach, KS 23454
1-888-755-5580, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Kentucky

Acentra Health (Kentucky's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, KY 32317
1-888-317-0751, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Louisiana

Acentra Health (Louisiana's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, LA 32317
1-888-315-0636, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Maine

Acentra Health (Maine's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, ME 32317
1-888-319-8452, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Maryland

Commence Health (Maryland's Quality Improvement Organization)
PO Box 2687
Virginia Beach, MD 23454
1-888-396-4646, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Massachusetts

Acentra Health (Massachusetts' Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, MA 32317
1-888-319-8452, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Michigan

Commence Health (Michigan's Quality Improvement Organization)
PO Box 2687
Virginia Beach, MI 23454
1-888-524-9900, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Minnesota

Commence Health (Minnesota's Quality Improvement Organization)
PO Box 2687
Virginia Beach, MN 23454
1-888-524-9900, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Mississippi

Acentra Health (Mississippi's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, MS 32317
1-888-317-0751, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Missouri

Commence Health (Missouri's Quality Improvement Organization)
PO Box 2687
Virginia Beach, MO 23454
1-888-755-5580, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Montana

Acentra Health (Montana's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, MT 32317
1-888-317-0891, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Nebraska

Commence Health (Nebraska's Quality Improvement Organization)
PO Box 2687
Virginia Beach, NE 23454
1-888-755-5580, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Nevada

Commence Health (Nevada's Quality Improvement Organization)
PO Box 2687
Virginia Beach, NV 23454
1-877-588-1123, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

New Hampshire

Acentra Health (New Hampshire's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, NH 32317
1-888-319-8452, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

New Jersey

Commence Health (New Jersey's Quality Improvement Organization)
PO Box 2687
Virginia Beach, NJ 23454
1-866-815-5440, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

New Mexico

Acentra Health (New Mexico's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, NM 32317
1-888-315-0636, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

New York

Commence Health (New York's Quality Improvement Organization)
PO Box 2687
Virginia Beach, NY 23454
1-866-815-5440, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

North Carolina

Acentra Health (North Carolina's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, NC 32317
1-888-317-0751, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

North Dakota

Acentra Health (North Dakota's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, ND 32317
1-888-317-0891, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Ohio

Commence Health (Ohio's Quality Improvement Organization)
PO Box 2687
Virginia Beach, OH 23454
1-888-524-9900, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Oklahoma

Acentra Health (Oklahoma's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, OK 32317
1-888-315-0636, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Oregon

Acentra Health (Oregon's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, OR 32317
1-888-305-6759, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Pennsylvania

Commence Health (Pennsylvania's Quality Improvement Organization)
PO Box 2687
Virginia Beach, PA 23454
1-888-396-4646, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Rhode Island

Acentra Health (Rhode Island's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, RI 32317
1-888-319-8452, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

South Carolina

Acentra Health (South Carolina's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, SC 32317
1-888-317-0751, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

South Dakota

Acentra Health (South Dakota's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, SD 32317
1-888-317-0891, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Tennessee

Acentra Health (Tennessee's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, TN 32317
1-888-317-0751, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Texas

Acentra Health (Texas's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, TX 32317
1-888-315-0636, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Utah

Acentra Health (Utah's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, UT 32317
1-888-317-0891, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Vermont

Acentra Health (Vermont's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, VT 32317
1-888-319-8452, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

Virginia

Commence Health (Virginia's Quality Improvement Organization)
PO Box 2687
Virginia Beach, VA 23454
1-888-396-4646, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Washington

Acentra Health (Washington's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, WA 32317
1-888-305-6759, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

West Virginia

Commence Health (West Virginia's Quality Improvement Organization)
PO Box 2687
Virginia Beach, WV 23454
1-888-396-4646, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Wisconsin

Commence Health (Wisconsin's Quality Improvement Organization)
PO Box 2687
Virginia Beach, WI 23454
1-888-524-9900, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, Saturday - Sunday
https://www.commencehealthqio.cms.gov/en

Wyoming

Acentra Health (Wyoming's Quality Improvement Organization)
1650 Summit Lake Dr.Suite 102
Tallahassee, WY 32317
1-888-317-0891, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
https://www.acentraqio.com/

SECTION 3 State Medicaid Offices

The following state agency information was updated on 07/15/2026. For more recent information or other questions, call Member Services.

Alabama

Alabama Medicaid
P.O. Box 5624
Montgomery, AL 36103-5624
1-334-242-5000, TTY: **1-800-253-0799**
8:00 a.m. - 4:30 p.m. CT, Monday - Friday
https://medicaid.alabama.gov/

Alaska

Alaska Medicaid
3601 C Street
Suite 902
Anchorage, AK 99503
1-800-780-9972, TTY: **711**
8:00 a.m. - 5:00 p.m. AKT, Monday - Friday
https://health.alaska.gov/en/

Arizona

Arizona Health Care Cost Containment System (AHCCCS)
150 N. 18th Avenue
Phoenix, AZ 85007
1-602-417-4000, TTY: **1-800-842-6520**
8:00 a.m. - 5:00 p.m. MT, Monday - Friday
https://www.azahcccs.gov/

Arkansas

Arkansas Medicaid
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. CT, Monday - Friday
https://humanservices.arkansas.gov/divisions-shared-services/medical-services/

California

California Medi-Cal (Medicaid)
P.O. Box 997413
MS 4400
Sacramento, CA 95899-7413
1-800-541-5555, TTY: **1-800-430-7077**
8:00 a.m. - 5:00 p.m. PT, Monday - Friday
https://www.dhcs.ca.gov/services/medi-cal-resources/

Colorado

Health First Colorado (Colorado's Medicaid Program)
303 E. 17th Avenue Suite 1100
Denver, CO 80203
1-800-221-3943, TTY: **711**
8:00 a.m. - 4:30 p.m. MT, Monday - Friday; closed on holidays
https://www.healthfirstcolorado.gov/

Connecticut

HUSKY Health For Connecticut Children & Adults (Medicaid)
P.O. Box 5005
Wallingford, CT 06492
1-855-805-4325, TTY: **711**
8:00 a.m. - 4:00 p.m., Monday - Friday
https://portal.ct.gov/husky

Delaware

Delaware Medicaid
1901 N DuPont Highway
New Castle, DE 19720
1-866-843-7212, TTY: **711**
8:00 a.m. - 4:30 p.m. ET, Monday - Friday
https://dhss.delaware.gov/dmma/

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. ET, Monday - Friday
https://dc.gov/service/medicaid

Florida

Florida Medicaid
2727 Mahan Drive
MS 62
Tallahassee, FL 32308
1-877-711-3662, TTY: **1-866-467-4970**
8:00 a.m. - 8:00 p.m. ET, Monday - Thursday 8:00 a.m. - 7:00 p.m. ET Friday
https://www.flmedicaidmanagedcare.com/home/index

Georgia

Georgia Medicaid
2 Martin Luther King Jr. Drive SE
East Tower
Atlanta, GA 30334
1-866-211-0950, TTY: **711**
8:00 a.m. - 5:00 p.m. ET, Monday - Friday
https://medicaid.georgia.gov/

Hawaii

Hawaii Med-QUEST (Medicaid)
1350 S. King Street
Suite 200
Honolulu, HI 96814
1-800-316-8005, TTY: **711**
7:45 a.m. - 4:30 p.m. HT, Monday - Friday
https://medquest.hawaii.gov/en.html

Idaho

Idaho Medicaid
1720 Westgate Drive
Boise, ID 83704
1-877-456-1233, TTY: **1-888-791-3004**
8:00 a.m. - 5:00 p.m. MT, Monday - Friday
https://healthandwelfare.idaho.gov/

Illinois

Illinois Medicaid
201 South Grand Avenue East
Springfield, IL 62763
1-800-843-6154, TTY: **1-855-889-4326**
7:30 a.m. - 7:00 p.m. CT, Monday - Friday
https://hfs.illinois.gov/medicalclients.html

Indiana

Indiana Medicaid
402 W. Washington Street
P.O. Box 7083
Indianapolis, IN 46204
1-800-457-4584, TTY: **711**
8:00 a.m. - 8:00 p.m. ET, Monday - Friday
https://www.in.gov/medicaid/

Iowa

Iowa Medicaid
321 East 12th St
Des Moines, IA 50319
1-800-338-8366, TTY: **1-800-735-2942**
8:00 a.m. - 5:00 p.m. CT, Monday - Friday
https://hhs.iowa.gov/

Kansas

KanCare Medicaid for Kansas
P.O. Box 3599
Topeka, KS 66601-9738
1-800-792-4884, TTY: **1-800-792-4292**
8:00 a.m. - 5:00 p.m. CT, Monday - Friday
https://www.kancare.ks.gov/

Kentucky

Kentucky Medicaid
275 E. Main St. 6W-A
Frankfort, KY 40601
1-855-459-6328, TTY: **1-800-627-4702**
8:00 a.m. - 4:30 p.m. ET, Monday - Friday
https://www.chfs.ky.gov/agencies/dms/Pages/default.aspx

Louisiana

Louisiana Medicaid
628 N. 4th Street
Baton Rouge, LA 70802
1-888-342-6207, TTY: **1-855-526-3346**
8:00 a.m. - 4:30 p.m. ET, Monday - Friday
https://ldh.la.gov/medicaid

Maine

MaineCare Services (Medicaid)
109 Capitol Street 11 State house Station
Augusta, ME 04333
1-866-690-5585, TTY: **711**
8:00 a.m. - 5:00 p.m. ET, Monday - Friday
https://www.maine.gov/dhhs/oms

Maryland

Maryland Medicaid
201 W. Preston Street
Baltimore, MD 21201-2399
1-410-767-6500, TTY: **1-800-735-2258**
8:30 a.m. - 5:00 p.m., Monday - Friday (excluding State holidays)
https://health.maryland.gov/mmcp/Pages/home.aspx

Massachusetts

Massachusetts MassHealth (Medicaid)
PO Box 4405
Taunton, MA 02780
1-800-841-2900, TTY: **711**
8:00 a.m. - 5:00 p.m. ET, Monday - Friday
https://www.mass.gov/topics/masshealth

Michigan

Michigan Medicaid
333 S. Grand Ave.
P.O. Box 30195
Lansing, MI 48909
1-517-241-3740, TTY: **711**
8:00 a.m. - 5:00 p.m. ET, Monday - Friday
https://www.michigan.gov/medicaid

Minnesota

Minnesota Medical Assistance (MA)
P.O. Box 64941
St. Paul, MN 55164-0941
1-800-657-3739, TTY: **711**
8:00 a.m. - 4:15 p.m. (closed from noon to 12:45 for lunch), Monday - Friday
https://mn.gov/dhs/health-care/medical-assistance/

Mississippi

Mississippi Division of Medicaid (DOM)
550 High Street
Suite 1000
Jackson, MS 39201
1-800-421-2408, TTY: **1-228-206-6062**
8:00 a.m. - 5:00 p.m. CT, Monday - Friday
https://medicaid.ms.gov/medicaid-coverage/

Missouri

MO HealthNet (Missouri Medicaid)
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102-6500
1-573-751-3425, TTY: **711**
8:00 a.m. - 5:00 p.m. CT, Monday - Friday
https://mydss.mo.gov/mhd/manage-my-health-care-benefit

Montana

Montana Medicaid
111 North Sanders
Helena, MT 59601-4520
1-800-362-8312, TTY: **711**
8:00 a.m. - 5:00 p.m. MT, Monday - Friday
https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices

Nebraska

Nebraska Medicaid
301 Centennial Mall South
Lincoln, NE 68509-5026
1-402-471-3121, TTY: **1-800-833-7352**
8:00 a.m. - 5:00 p.m., Monday - Friday
https://dhhs.ne.gov/Pages/Medicaid-Eligibility.aspx

Nevada

Nevada Medicaid
4070 Silver Sage Drive
Carson City, NV 89701
1-877-638-3472, TTY: **711**
8:00 a.m. - 5:00 p.m. PT, Monday - Friday
https://www.medicaid.nv.gov/

New Hampshire

New Hampshire Medicaid
129 Pleasant St.
Concord, NH 03301
1-844-275-3447, TTY: **1-800-735-2964**
8:00 a.m. - 4:00 p.m. ET, Monday - Friday
https://www.dhhs.nh.gov/programs-services/medicaid

New Jersey

New Jersey Family Care (Medicaid)
222 South Warren Street
P.O. Box 700
Trenton, NJ 08625-0700
1-800-701-0710, TTY: **711**
8:00 a.m. - 8:00 p.m. ET, Monday, Thursday, 8:00 a.m. - 5:00 p.m. ET, Tuesday, Wednesday, Friday
https://njfamilycare.dhs.state.nj.us/

New Mexico

New Mexico Turquoise Care (Medicaid)
P.O. Box 2348
Santa Fe, NM 87504-2348
1-800-283-4465, TTY: **711**
7:00 a.m. - 6:30 p.m., Monday - Friday
https://www.hca.nm.gov/

New York

New York State Medicaid
99 Washington Avenue
Albany, NY 12210-2808
1-800-541-2831, TTY: **1-800-662-1220**
8:00 a.m. - 8:00 p.m. ET, Monday - Friday, and Saturday from 9:00 a.m. - 1:00 p.m.
https://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. ET, Monday - Friday, Closed on State holidays
https://ncgov.servicenowservices.com/sp_beneficiary?id=bnf_index

North Dakota

North Dakota Medicaid
600 E Boulevard Ave
Dept. 325
Bismarck, ND 58505-0250
1-701-328-7068, TTY: **711**
8:00 a.m. - 5:00 p.m. CT, Monday - Friday
https://www.hhs.nd.gov/healthcare/medicaid

Ohio

Ohio Medicaid
50 West Town Street
Suite 400
Columbus, OH 43215
1-800-324-8680, TTY: **711**
7:00 a.m. - 8:00 p.m. ET, Monday - Friday, Saturday 8:00 a.m. - 5:00 p.m.
https://medicaid.ohio.gov/home

Oklahoma

Oklahoma SoonerCare (Medicaid)
4345 N Lincoln Boulevard
Oklahoma City, OK 73105
1-800-987-7767, TTY: **711**
8:00 a.m. - 5:00 p.m. CT, Monday - Friday
https://oklahoma.gov/ohca.html

Oregon

Oregon Health Plan (Medicaid)
P.O. Box 14015
Salem, OR 97309
1-800-699-9075, TTY: **711**
7:00 a.m. - 6:00 p.m. PT, Monday - Friday
https://www.oregon.gov/OHA/HSD/OHP/Pages/index.aspx

Pennsylvania

Pennsylvania Medical Assistance (Medicaid)
801 Market St
Philadelphia, PA 19107
1-800-692-7462, TTY: **1-800-451-5886**
8:30 a.m. - 4:45 p.m. ET, Monday - Friday
https://www.pa.gov/agencies/dhs/resources/medicaid

Rhode Island

Rhode Island Medicaid
P.O. Box 8709
Cranston, RI 02920-8787
1-855-697-4347, TTY: **711**
8:30 a.m. - 3:30 p.m., Monday - Friday
https://www.eohhs.ri.gov/Consumer/ConsumerInformation.aspx

South Carolina

South Carolina Healthy Connections (Medicaid)
P.O. Box 8206
Columbia, SC 29202-8206
1-888-549-0820, TTY: **1-888-842-3620**
8:00 a.m. - 6:00 p.m. ET, Monday - Friday
https://www.scdhhs.gov/

South Dakota

South Dakota Medicaid
700 Governors Drive
Pierre, SD 57501
1-800-452-7691, TTY: **711**
8:00 a.m. - 4:30 p.m. CT, Monday - Friday
https://dss.sd.gov/medicaid/

Tennessee

Tennessee TennCare (Medicaid)
310 Great Circle Rd.
Nashville, TN 37243
1-855-259-0701, TTY: **1-877-779-3103**
7:00 a.m. - 6:00 p.m. CT, Monday - Friday
https://www.tn.gov/tenncare/

Texas

Texas Medicaid
4601 W. Guadalupe St.
P.O. Box 13247
Austin, TX 78751-3146
1-877-541-7905, TTY: **711**
8:00 a.m. - 4:00 p.m. CT, Monday - Friday
https://hhs.texas.gov/services/health/medicaid-chip

Utah

Utah Medicaid
288 North 1460 West
Salt Lake City, UT 84116
1-866-608-9422, TTY: **711**
8:00 a.m. - 5:00 p.m. MT, Monday - Friday; 11:00 a.m. - 5:00 p.m. MT, Tuesday (excluding State holidays)
https://medicaid.utah.gov/

Vermont

Department of Vermont Health Access (Medicaid)
280 State Dr. NOB 1 South
Waterbury, VT 05671-1010
1-800-250-8427, TTY: **711**
7:45 a.m. - 4:30 p.m. ET, Monday - Friday
https://dvha.vermont.gov/members/medicaid

Virginia

Virginia Medicaid
600 E. Broad St.
Richmond, VA 23219
1-855-242-8282, TTY: **1-888-221-1590**
8:00 a.m. - 7:00 p.m. ET, Monday - Friday, 9:00 a.m. - 12:00 p.m. ET, Saturday
https://www.dmas.virginia.gov/

Washington

Washington Apple Health (Medicaid)
PO Box 45531
Olympia, WA 98504
1-800-562-3022, TTY: **711**
7:00 a.m. - 5:00 p.m. PT, Monday - Friday (excluding State holidays)
https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care

West Virginia

West Virginia Medicaid
350 Capitol St
Rm 251
Charleston, WV 25301
1-304-558-1700, TTY: **1-866-430-1274**
8:00 a.m. - 5:00 p.m. ET, Monday - Friday, Closed on State holidays
https://bms.wv.gov/

Wisconsin

Wisconsin Medicaid
201 E. Washington Ave.
Madison, WI 53703
1-608-266-1865, TTY: **711**
8:00 a.m. - 4:30 p.m. CT, Monday - Friday
https://www.dhs.wisconsin.gov/medicaid/index.htm

Wyoming

Wyoming Medicaid
122 W 25th St.
4th Floor West
Cheyenne, WY 82001
1-307-777-7531, TTY: **1-855-329-5204**
9:00 a.m. - 5:00 p.m. MT, Monday - Friday
https://health.wyo.gov/healthcarefin/medicaid

SECTION 4 State Medicare Offices

The following state agency information was updated on 07/15/2026. For more recent information or other questions, call Member Services.

Alabama

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
https://www.medicare.gov

Alaska

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
https://www.medicare.gov

Arizona

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
https://www.medicare.gov

Arkansas

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
https://www.medicare.gov

California

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
https://www.medicare.gov

Colorado

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
https://www.medicare.gov

Connecticut

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
https://www.medicare.gov

Delaware

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
https://www.medicare.gov

District of Columbia

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
https://www.medicare.gov

Florida

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
https://www.medicare.gov

Georgia

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
https://www.medicare.gov

Hawaii

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
https://www.medicare.gov

Idaho

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
https://www.medicare.gov

Illinois

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
https://www.medicare.gov

Indiana

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
https://www.medicare.gov

Iowa

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
https://www.medicare.gov

Kansas

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
https://www.medicare.gov

Kentucky

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
https://www.medicare.gov

Louisiana

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
https://www.medicare.gov

Maine

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
https://www.medicare.gov

Maryland

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
https://www.medicare.gov

Massachusetts

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
https://www.medicare.gov

Michigan

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
https://www.medicare.gov

Minnesota

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
https://www.medicare.gov

Mississippi

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
https://www.medicare.gov

Missouri

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
https://www.medicare.gov

Montana

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
https://www.medicare.gov

Nebraska

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
https://www.medicare.gov

Nevada

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
https://www.medicare.gov

New Hampshire

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
https://www.medicare.gov

New Jersey

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
https://www.medicare.gov

New Mexico

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
https://www.medicare.gov

New York

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
https://www.medicare.gov

North Carolina

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
https://www.medicare.gov

North Dakota

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
https://www.medicare.gov

Ohio

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
https://www.medicare.gov

Oklahoma

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
https://www.medicare.gov

Oregon

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
https://www.medicare.gov

Pennsylvania

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
https://www.medicare.gov

Rhode Island

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
https://www.medicare.gov

South Carolina

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
https://www.medicare.gov

South Dakota

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
https://www.medicare.gov

Tennessee

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
https://www.medicare.gov

Texas

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
https://www.medicare.gov

Utah

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
https://www.medicare.gov

Vermont

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
https://www.medicare.gov

Virginia

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
https://www.medicare.gov

Washington

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
https://www.medicare.gov

West Virginia

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
https://www.medicare.gov

Wisconsin

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
https://www.medicare.gov

Wyoming

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
https://www.medicare.gov

SECTION 5 State Pharmaceutical Assistance Program (SPAP)

The following state agency information was updated on 07/15/2026. For more recent information or other questions, call Member Services.

Delaware

Delaware Prescription Assistance Program (DPAP)
P.O. Box 950
New Castle, DE 19720-0950
1-800-996-9969, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://dhss.delaware.gov/dmma/home/dpap/

Idaho

Idaho AIDS Drug Assistance Program (ADAP)
P.O. Box 83720
Boise, ID 83720
1-208-985-3019, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://healthandwelfare.idaho.gov/health-wellness/diseases-conditions/human-immunodeficiency-virus-hiv

Indiana

Hoosier Rx
402 W. Washington Street Room W372, MS07
Indianapolis, IN 46204
1-866-267-4679, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.in.gov/medicaid/members/member-programs/hoosierrx/

Maine

Drugs for the Elderly and Disabled
109 Capitol Street 11 State House Station
Augusta, ME 04333
1-800-977-6740, TTY: **711**
7:00 a.m. - 6:00 p.m. local time, Monday - Friday
https://www.maine.gov/dhhs/oms/mainecare-options/covered-services-benefits#:~:text=Drugs%20for%20the%20Elderly%20and,t
00%20copayment.

Maryland

Senior Prescription Drug Assistance Program (SPDAP)
P.O. Box 749
Greenbelt, MD 20768-0749
1-800-551-5995, TTY: **1-800-877-5156**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://marylandspdap.com/

Massachusetts

Massachusetts Prescription Advantage
P.O. Box 15153
Worcester, MA 01615-0153
1-800-243-4636, TTY: **1-800-439-2370**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.mass.gov/info-details/prescription-advantage-documents-and-resources

Missouri

Missouri Rx Plan (MORx)
615 Howerton Court P.O. Box 6500
Jefferson City, MO 65102-6500
1-573-751-3425, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://mydss.mo.gov/mhd/morx-general-faqs

New Jersey

Pharmaceutical Assistance to the Aged and Disabled (PAAD)
P.O. Box 715
Trenton, NJ 08625-0715
1-800-792-9745, TTY: **1-877-294-4356**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.nj.gov/humanservices/doas/services/l-p/paad/

New Mexico

The New Mexico Prescription Drug Assistance Program (PDA)
2550 Cerrillos Road
Santa Fe, NM 87505
1-800-432-2080, TTY: **1-505-476-4937**
7:45 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.aging.nm.gov/consumer-and-elder-rights/prescription-drug-assistance/

New York

New York State Elderly Pharmaceutical Insurance Coverage (EPIC)
P.O. Box 15018
Albany, NY 12212-5018
1-800-332-3742, TTY: **1-800-290-9138**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.health.ny.gov/health_care/epic/

North Carolina

The North Carolina HIV Medication Assistance Program (NC HMAP)
1902 Mail Service Center
Raleigh, NC 27699
1-888-311-7632, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html

Pennsylvania

Pharmaceutical Assistance Contract for the Elderly (PACE) Program and PACENET
P.O. Box 8806
Harrisburg, PA 17105-8806
1-800-225-7223, TTY: **711**
8:30 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.pa.gov/agencies/aging/aging-programs-and-services/pace-program

Rhode Island

Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)
25 Howard Ave Bldg 57
Cranston, RI 02920
1-401-462-0560, TTY: **1-401-462-0740**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://oha.ri.gov/resources/health-insurance-health-care-cost-assistance/drug-cost-assistance

Texas

Texas THMP State Pharmacy Assistance Program (SPAP)
P.O. Box 149347
Austin, TX 78714-9947
1-888-963-7111, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.dshs.texas.gov/hivstd/meds/spap

Virginia

Virginia Medication Assistance Program (VA MAP)
109 Govenor Street
Richmond, VA 23219
1-855-362-0658, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.vdh.virginia.gov/disease-prevention/vamap/

Vermont

Healthy Vermonters / Vpharm
280 State Drive NOB 1 South
Waterbury, VT 05671-1500
1-800-250-8427, TTY: **711**
7:45 a.m. - 4:30 p.m. local time, Monday - Friday
https://dvha.vermont.gov/members/prescription-assistance

Wisconsin

Wisconsin SeniorCare
P.O. Box 6710
Madison, WI 53716-0710
1-800-657-2038, TTY: **711**
8:00 a.m. - 6:00 p.m. local time, Monday - Friday
https://www.dhs.wisconsin.gov/seniorcare/index.htm

SECTION 6 Civil Rights Commission

The following state agency information was updated on 07/15/2026. For more recent information or other questions, call 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**
8:00 a.m. - 4:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
7:30 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
9:30 a.m. - 3:30 p.m.
OCRComplaint@hhs.gov
https://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**
9:30 a.m. - 3:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 4:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 4:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 4:30 p.m.
OCRComplaint@hhs.gov
https://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**
7:30 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
9:30 a.m. - 3:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 4:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
7:30 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 4:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
7:30 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
9:30 a.m. - 3:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 4:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 4:30 p.m.
OCRComplaint@hhs.gov
https://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**
7:30 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
9:30 a.m. - 3:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://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**
9:30 a.m. - 3:30 p.m.
OCRComplaint@hhs.gov
https://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**
8:30 a.m. - 5:00 p.m.
OCRComplaint@hhs.gov
https://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**
8:00 a.m. - 8:00 p.m.
OCRComplaint@hhs.gov
https://www.hhs.gov/ocr

SECTION 7 AIDS Drug Assistance Program (ADAP)

The following state agency information was updated on 07/15/2026. For more recent information or other questions, call Member Services.

Alabama

Alabama AIDS Drug Assistance Program (ADAP)
201 Monroe Street
Suite 1200
Montgomery, AL 36104
1-866-574-9964, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.alabamapublichealth.gov/hiv/adap.html

Alaska

The AIDS Drug Assistance Program (ADAP)
1057 W. Fireweed Lane
Suite 102
Anchorage, AK 99503
1-907-263-2050, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.alaskanaids.org/

Arizona

The AIDS Drug Assistance Program (ADAP)
150 N. 18th Ave
Phoenix, AZ 85007
1-602-542-1025, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.azdhs.gov/preparedness/bureau-of-infectious-disease-and-services/hiv-hepatitis-c-services/index.php#aids-drug-assistance-program-home

Arkansas

AIDS Drug Assistance Program (ADAP)
4815 West Markham Street
Little Rock, AR 72205-3867
1-800-462-0599, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://healthy.arkansas.gov/programs-services/diseases-conditions/infectious-disease/ryan-white-program/

California

The AIDS Drug Assistance Program (ADAP)
MS 0500
P.O. Box 997377
Sacramento, CA 95899-7377
1-844-421-7050, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday (excluding holidays)
https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx

Colorado

The Colorado State Drug Assistance Program (SDAP)
4300 Cherry Creek Drive South
Denver, CO 80246
1-303-692-2000, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://cdphe.colorado.gov/state-drug-assistance-program

Connecticut

Connecticut AIDS Drug Assistance Program (CADAP)
410 Capitol Ave.
Hartford, CT 06134
1-800-424-3310, TTY: **711**
8:00 a.m. - 4:00 p.m. local time, Monday - Friday
https://ctdph.primetherapeutics.com/

Delaware

The 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. local time, Monday - Friday
https://www.ramsellcorp.com/medical_professionals/de.aspx

District of Columbia

DC Pharmacy Benefits Program
2201 Shannon Place SE
Washington, DC 20020
1-202-671-4815, TTY: **711**
Monday - Friday 8:15 a.m. - 4:45 p.m.
https://dchealth.dc.gov/Pharmacy_Benefits_Program

Florida

The AIDS Drug Assistance Program (ADAP)
4052 Bald Cypress Way
Tallahassee, FL 32399
1-844-381-2327, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.floridahealth.gov/individual-family-health/injury-prevention-wellness/hiv-aids/hiv-aids-management/

Georgia

Georgia AIDS Drug Assistance Program (ADAP)
200 Piedmont Avenue
SE
Atlanta, GA 30334
1-404-656-9805, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap

Hawaii

HIV Drug Assistance Program (HDAP)
3627 Kilauea Ave
Suite 306
Honolulu, HI 96816
1-808-733-9360, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/

Idaho

Idaho AIDS Drug Assistance Program (ADAP)
450 W. State Street
P.O. Box 83720
Boise, ID 83720
1-208-985-3019, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://healthandwelfare.idaho.gov/health-wellness/diseases-conditions/human-immunodeficiency-virus-hiv

Illinois

The AIDS Drug Assistance Program
(ADAP-Medication Assistance)
525 West Jefferson Street
1st Floor
Springfield, IL 62761
1-800-825-3518, TTY: **711**
8:30 a.m. - 5:00 p.m. local time, Monday - Friday
https://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services.html

Indiana

The AIDS Drug Assistance Program (ADAP)
2 N Meridian St
Suite 6C
Indianapolis, IN 46204
1-866-588-4948, TTY: **711**
8:15 a.m. - 4:45 p.m. local time, Monday - Friday
https://www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/

Iowa

AIDS Drug Assistance Program (ADAP)
321 E. 12th Street
Des Moines, IA 50319
1-800-972-2017, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://hhs.iowa.gov/health-prevention/hiv-sti-and-hepatitis/hivaids-program

Kansas

AIDS Drug Assistance Program (ADAP)
1000 SW Jackson
Suite 540
Topeka, KS 66612
1-785-296-1086, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program

Kentucky

Kentucky AIDS Drug Assistance Program
(KADAP)
275 East Main Street
HS2E-C
Frankfort, KY 40621
1-866-510-0005, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

Louisiana

The Louisiana Health Access Program (LA HAP)
1450 Poydras St
Suite 2136
New Orleans, LA 70112
1-504-568-7474, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://lahap.org/

Maine

The AIDS Drug Assistance Program (ADAP)
40 State House Station
Augusta, ME 04330
1-207-287-3747, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.maine.gov/dhhs/mecdc/diseases-conditions/sexually-transmitted-diseases/hiv-aids

Maryland

The Maryland AIDS Drug Assistance Program (MADAP)
201 W. Preston Street
Baltimore, MD 21201
1-410-767-6535, TTY: **1-800-735-2258**
8:30 a.m. - 4:30 p.m. local time, Monday - Friday
https://health.maryland.gov/phpa/IDPHSB/Pages/MADAP.aspx

Massachusetts

The HIV Drug Assistance Program (HDAP)
529 Main Street
Suite 301
Boston, MA 02129
1-617-502-1700, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://crihealth.org/drug-assistance/hdap/

Michigan

The Michigan Drug Assistance Program (MIDAP)
P.O. Box 30727
Lansing, MI 48913
1-888-826-6565, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program/michigan-drug-assistance-program

Minnesota

HIV Medication Program (ADAP)
P.O. Box 64972
St. Paul, MN 55164-0972
1-651-431-2414, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://mn.gov/dhs/health-care/hiv-aids/programs-services/medications/

Mississippi

HIV Care and Treatment Program
Post Office Box 1700
Jackson, MS 39215
1-601-362-4879, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://msdh.ms.gov/msdhsite/_static/14,13047,150.html

Missouri

Missouri AIDS Drug Assistance Program (ADAP)
P.O. Box 570
Jefferson City, MO 65102
1-888-252-8045, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://health.mo.gov/living/healthcondiseases/communicable/hivaids/adap.php

Montana

Montana Ryan White HIV Treatment Program
1400 Broadway
Helena, MT 59620
1-406-444-3565, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://dphhs.mt.gov/publichealth/hivstd/Treatment/mtryanwhiteprog

Nebraska

The Ryan White HIV/AIDS Program (RWHAP)
P.O. Box 95026
Lincoln, NE 68509-5026
1-402-471-3121, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://dhhs.ne.gov/Pages/HIV-Care.aspx

Nevada

Nevada Medication Assistance Program (NMAP)
2290 S. Jones Blvd
Suite 110
Las Vegas, NV 89146
1-702-486-0768, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://endhivnevada.org/ryan-white-care/

New Hampshire

The AIDS Drug Assistance Program (ADAP)
29 Hazen Drive
Concord, NH 03301
1-800-852-3345, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-aids

New Jersey

The AIDS Drug Distribution Program (ADDP)
P.O. Box 722
Trenton, NJ 08625
1-877-613-4533, TTY: **711**
9:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml

New Mexico

New Mexico AIDS Drug Assistance Program (NM ADAP)
1190 S. St. Francis Drive
Suite S-1200
Santa Fe, NM 87502
1-505-476-3628, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.nmhealth.org/about/phd/idb/hats/

New York

The AIDS Drug Assistance Program (ADAP)
P.O. Box 2052
Albany, NY 12220
1-800-542-2437, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.health.ny.gov/diseases/aids/general/resources/adap/

North Carolina

The North Carolina HIV Medication Assistance Program (NC HMAP)
1902 Mail Service Center
Raleigh, NC 27699
1-877-466-2232, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html

North Dakota

North Dakota Department of Health HIV, STD, TB Viral Hepatitis Program
600 East Boulevard Ave
Bismarck, ND 58505-0250
1-701-328-2378, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.hhs.nd.gov/health/diseases-conditions-and-immunization/north-dakota-ryan-white-part-b-program

Ohio

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

Oklahoma

The AIDS Drug Assistance Program (ADAP)
123 Robert S. Kerr Ave. Ste 1702
Oklahoma City, OK 73102-6406
1-405-426-8400, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://oklahoma.gov/health/services/personal-health/sexual-health-and-harm-reduction-service/community-resources---partners.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. local time, Monday - Friday
https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx

Pennsylvania

The AIDS Drug Assistance Program (ADAP)
P.O. Box 8808
Harrisburg, PA 17105-8808
1-800-922-9384, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.pa.gov/agencies/health/diseases-conditions/infectious-disease/hiv/special-pharmaceutical-benefits

Rhode Island

The AIDS Drug Assistance Program (ADAP)
3 West Road
Suite 227
Cranston, RI 02920
1-401-462-3295, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx

South Carolina

The AIDS Drug Assistance Program (ADAP)
Milla Jarret Box 101106
3rd Floor
Columbia, SC 29211
1-800-856-9954, TTY: **711**
8:30 a.m. - 5:00 p.m. local time, Monday - Friday
https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program

South Dakota

Ryan White Part B CARE Program (ADAP)
615 E. 4th St.
Pierre, SD 57501
1-605-367-4795, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://doh.sd.gov/topics/diseases/disease-prevention-services/hivaids/ryan-white-part-b-program/

Tennessee

Ryan White Part B Program (ADAP)
710 James Robertson Parkway
4th Floor, Andrew Johnson Tower
Nashville, TN 37243
1-615-741-7500, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://www.tn.gov/health/tnhiv.html

Texas

The Texas HIV Medication Program (THMP)
PO Box 149347
Austin, TX 78714
1-800-255-1090, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://www.dshs.texas.gov/hivstd/meds

Utah

The AIDS Drug Assistance Program (ADAP)
288 North 1460 West
Salt Lake City, UT 84116
1-801-538-6191, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://epi.utah.gov/ryan-white/

Vermont

The Vermont Medication Assistance Program (VMAP)
108 Cherry Street
P.O. Box 70
Burlington, VT 05402
1-802-951-4005, TTY: **711**
7:45 a.m. - 4:30 p.m. local time, Monday - Friday
https://www.healthvermont.gov/disease-control/sexual-health-and-sexually-transmitted-infections/hiv-treatment-and-care

Virginia

The Virginia Medication Assistance Program (VA MAP)
109 Governor Street
Richmond, VA 23219
1-855-362-0658, TTY: **711**
8:00 a.m. - 5:00 p.m. local time Monday - Friday
https://www.vdh.virginia.gov/disease-prevention/vamap/

Washington

The Early Intervention Program (EIP)
P.O. Box 47841
Olympia, WA 98504
1-877-376-9316, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early-intervention-program

West Virginia

West Virginia AIDS Drug Assistance Program (ADAP)
P.O. Box 6360
Wheeling, WV 26003
1-304-232-6822, TTY: **711**
9:00 a.m. - 4:00 p.m. local time, Monday - Friday
https://oeps.wv.gov/ryan-white-program

Wisconsin

HIV Drug Assistance Program (HDAP)
P.O. Box 2659
Madison, WI 53701
1-800-991-5532, TTY: **711**
8:00 a.m. - 4:30 p.m. local time, Monday - Friday
https://www.dhs.wisconsin.gov/hiv/hdap.htm

Wyoming

The AIDS Drug Assistance Program (ADAP)
122 West 25th Street
3rd Floor West
Cheyenne, WY 82002
1-307-777-7656, TTY: **711**
8:00 a.m. - 5:00 p.m. local time, Monday - Friday
https://health.wyo.gov/publichealth/communicable-disease-unit/hiv-treatment-program/hiv-treatment-resources-for-patients/

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English – ATTENTION: If you need help in your language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the phone number on your member ID card.

Español (Spanish) – ATENCIÓN: Si necesita ayuda en su idioma, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono que figura en su tarjeta de identificación del miembro.

العربية (Arabic) – تنبيه: إذا كنت تحتاج إلى المساعدة بلغتك، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجانا. اتصل برقم الهاتف الموجود على بطاقة هوية العضو الخاصة بك.

繁體中文 (Chinese) – 注意：如果您在您的語言方面需要協助，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打您的會員 ID 卡上的電話號碼。

Français (French) – ATTENTION : Si vous avez besoin d'aide dans votre langue, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone figurant sur votre carte d'ID de membre.

Deutsch (German) – ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die Telefonnummer auf Ihrer Mitglieds-ID-Karte an.

ગુજરાતી (Gujarati) – ધ્યાન આપો: જો તમને તમારી ભાષામાં મદદની જરૂર છે, તો તમારા માટે વિના મૂલ્યે ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા સભ્ય ID કાર્ડ પર આપેલા ફોન નંબર પર કૉલ.

हिंदी (Hindi) – ध्यान दें: यदि आपको अपनी भाषा में सहायता चाहिए, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। पहुँच योग्य प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। अपने सदस्य ID कार्ड पर दिए गए फ़ोन नंबर पर कॉल करें।

Italiano (Italian) –ATTENZIONE: se hai bisogno di supporto nella tua lingua, sono disponibili servizi di assistenza linguistica gratuita. Sono inoltre disponibili gratuitamente adeguati supporti e servizi per ottenere informazioni in formato accessibile. Chiamare il numero di telefono riportato sulla propria tessera associativa.

日本語 (Japanese) – 注意：ご使用の言語でのサポートが必要な場合には、無料の言語支援サービスをご提供しています。適切な補助器具・サービスも、利用者がアクセスしやすい方法でご提供しています。こちらも無料でご利用いただけます。必要な情報取得にお役立てください。会員 ID カードに記載されている電話番号にお電話くだ さい。

한국어(Korean) – 주의: 귀하의 언어로 도움이 필요하신 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 가입자 ID 카드에 기재된 전화 번호로 전화해 주십시오.

Português (Portuguese) – ATENÇÃO: Se necessita de ajuda no seu idioma, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone indicado no seu cartão de identificação de membro.

Русский (Russian) – ВНИМАНИЕ: Если вам нужна помощь на вашем языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по номеру телефона, указанному на вашей ID-карте участника.

Tagalog (Tagalog) – PAUNAWA: Kung kailangan mo ng tulong sa iyong wika, mayroong libreng serbisyo para sa iyo. Available din ang naaangkop na tulong at serbisyo na nagbibigay ng impormasyon sa iyong wika. Ito ay libre rin. Tawagan ang numero ng telepono sa iyong member ID card.

తెలుగు (Telugu) – గమనిక: మీకు మీ భాషలో సహాయం అవసరమైతే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు, సేవలు కూడా ఉచితంగా లభిస్తాయి. మీ మెంబర్ ID కార్డులోని ఫోన్ నెంబర్‌కు కాల్ చేయండి.

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại trên thẻ ID thành viên của quý vị.

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Anthem

Pharmacy Member Services - Contact Information

Call: For questions related to pharmacy benefits, call us at **1-833-285-4636**. Calls to this number are always free.
24 hours a day, 7 days a week
Pharmacy Member Services also has free language interpreter services for non-English speakers.

TTY: **711**. This number requires special telephone equipment and is only for people who have difficulties 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.

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.