EXPRESS SCRIPTS®
Medicare (PDP)

Commonwealth of Virginia
Retiree Health Benefits Program

January 1 – December 31, 2018

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of Express Scripts Medicare (PDP) for the Commonwealth of Virginia Retiree Health Benefits Program

This document gives you general information about your Medicare prescription drug coverage from January 1 – December 31, 2018. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place. For specific plan information, please refer to your *Benefit Overview* or *Annual Notice of Changes.***

This plan, **Express Scripts Medicare**® (PDP), is offered by Medco Containment Life Insurance Company. (When this *Evidence of Coverage* says "we," "us" or "our," it means Medco Containment Life Insurance Company. When it says "plan" or "our plan," it means Express Scripts Medicare.)

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

Express Scripts Medicare Customer Service: 1.800.572.4098 (TTY users call: 1.800.716.3231)

For more help or information, please contact Express Scripts Medicare Customer Service at the numbers above (also on the back of your member ID card) or go to our plan website at **https://www.express-scripts.com**. Calls to Customer Service are free. Customer Service is available 24 hours a day, 7 days a week. Customer Service has free language interpreter services available for non-English speakers.

This information is available in braille. Please contact Customer Service at the numbers above if you need plan information in another format.

This information is available for free in other languages. Please contact Customer Service at the numbers on the back of your member ID card and the front of this document for additional information. Customer Service is available 24 hours a day, 7 days a week. Esta información está disponible sin cargo en otros idiomas. Comuníquese con el Servicio de atención al cliente de Express Scripts Medicare llamando a los números que figuran al dorso de su tarjeta de identificación de miembro para obtener información adicional. El Servicio de atención al cliente está disponible las 24 horas, los 7 días de la semana.

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

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2018 Evidence of Coverage

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Chapter 1. Getting started as a member of Express Scripts Medicare

SECTION 1 Introduction

Section 1.1 You are enrolled in Express Scripts Medicare, which is a Medicare prescription drug plan

Your former employer or your retiree group has chosen to get your Medicare prescription drug coverage through our plan, Express Scripts Medicare. In this document, "your former employer's plan" or "retiree group" means the Commonwealth of Virginia Retiree Health Benefits Program. Your "group benefits administrator" means your designated Commonwealth of Virginia Benefits Administrator. Your annual rate notification booklet from the Commonwealth of Virginia Retiree Health Benefits Program will include information to assist you in identifying your Benefits Administrator.

There are different types of Medicare plans. Express Scripts Medicare is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

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

This *Evidence of Coverage* tells you how to get your Medicare prescription drug coverage through our plan. It explains your rights and responsibilities and what is covered.

The words "coverage" and "covered drugs" refer to the prescription drug coverage available to you as a member of Express Scripts Medicare.

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

If you are confused or concerned or just have a question, please contact our plan's Customer Service (contact information is listed on the front of this document and the back of your member ID card).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Express Scripts Medicare covers your care. Other parts of this contract include your eligibility record, the 2018 *Formulary (List of Covered Drugs),* your *Benefit Overview,* your *Annual Notice of Changes* packet, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Express Scripts Medicare between January 1, 2018, and December 31, 2018.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Express Scripts Medicare after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018, within the requirements of our contract with the Commonwealth of Virginia Department of Human Resource Management.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services, or CMS) must approve Express Scripts Medicare each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and remain in compliance with our contract with the Commonwealth of Virginia Department of Human Resource Management, your former employer continues to offer this plan, you remain eligible under your former employer's plan, and CMS renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You live in our geographic service area (**Section 2.3** below describes our service area)
- You are entitled to Medicare Part A and/or enrolled in Medicare Part B (or you have both Part A and Part B) (**Section 2.2** tells you about Medicare Part A and Medicare Part B)
- You are a United States citizen or are lawfully present in the United States
- Your former employer or your retiree group has submitted you for enrollment in this plan
- Medicare approves your enrollment

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

As long as you meet the requirements noted in the previous section, you will receive prescription drug coverage (sometimes called Medicare Part D) through this plan. Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. This document and other plan materials you have received, such as the *Benefit Overview* or *Annual Notice of Changes,* describe that coverage.

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physicians' services and other outpatient services) and certain items (such as durable medical equipment and supplies).
- Medicare outpatient prescription drug coverage falls under Medicare Part D.

Section 2.3 Here is the plan service area for Express Scripts Medicare

Medicare is a Federal program. Express Scripts Medicare is available only to individuals who qualify for coverage from their former employer or retiree group and live in our plan service area. To stay a member of our plan, you must keep living in this service area. Our service area includes all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

If you plan to move, please contact your group benefits administrator to update your address.

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

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare prescription drug plan must be a U.S. citizen or lawfully present in the United States. Medicare will notify Express Scripts Medicare if you are not eligible to remain a member on this basis. Express Scripts Medicare must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your member ID card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your member ID card for prescription drugs you get at network pharmacies. Below is a sample member ID card to show you what yours may look like, but your card may look slightly different.

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (The phone numbers for Customer Service are listed on the back of your member ID card and on the front of this document.)

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare, Parts A and B. You will also have separate ID cards for your Medicare supplemental coverage and dental coverage, if applicable, in which you are enrolled through the Commonwealth of Virginia Retiree Health Benefits Program.

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

How do you find participating network pharmacies?

Our *Pharmacy Directory* gives you a list of the retail network pharmacies closest to your address of record — that means the pharmacies in your area that have agreed to fill covered prescriptions for our plan members — as well as other pharmacies (such as long-term care pharmacies) in our network.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them. There may be changes to our network of pharmacies for 2018.

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are listed on the front of this document and on the back of your member ID card). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information or locate current retail network pharmacies near you by visiting our website at **https://www.express-scripts.com**.

Section 3.3 The plan's 2018 *Formulary (List of Covered Drugs)*

The plan has a *Formulary (List of Covered Drugs)* for the 2018 plan year. We call it the "Drug List" for short. It tells which commonly used Part D prescription drugs are covered by Express Scripts Medicare. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The Express Scripts Medicare Drug List meets requirements set by Medicare and has been approved.

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

To get the most complete and current information about which drugs are covered, call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document).

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

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

The Part D EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. **Chapter 4** (*Paying for your Part D prescription drugs*) gives more information about the Part D EOB and how it can help you keep track of your drug coverage.

A Part D EOB summary is also available upon request. To get a copy, please contact Customer Service. In addition to receiving your Part D EOB in the mail, you can receive a copy electronically by visiting our website, **https://www.express-scripts.com**.

SECTION 4 Your monthly premium for Express Scripts Medicare

Section 4.1 Your plan premium

Your coverage is provided through a contract with your former employer or your retiree group. Your premium for this coverage is a part of your total State Retiree Health Benefits Program premium if you are enrolled for this coverage. Your premium cost is provided in your annual rate notification materials from the Commonwealth of Virginia Retiree Health Benefits Program. If you have questions about your plan premium, please contact your group benefits administrator for more information.

If your former employer or your retiree group charges you a plan premium or a portion of the plan premium, you are required to pay the premium according to their instructions.

If your former employer or your retiree group has not received your plan premium when it is due, you will be notified of your past-due balance and the potential for termination of your coverage if not resolved.

If your membership is ended due to nonpayment of premiums, it will not affect your coverage under Medicare Parts A and B. Under your former employer's plan, you may not reinstate this coverage once it has been either declined or terminated.

However, if you think your membership has been wrongfully ended, please contact your group benefits administrator to determine what steps to follow in order to have your coverage reinstated. **Chapter 7, Section 7** tells how to make a complaint to Express Scripts Medicare. In addition, you must continue to pay any applicable Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by contacting Customer Service at the numbers on the front of this document. You must make your request no later than 60 days after the date your membership ends.

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

There are programs to help people with limited resources pay for their drugs. These include the Extra Help and State Pharmaceutical Assistance Programs. **Chapter 4** tells more about these programs. If you qualify, enrolling in one or both of these programs might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **some of the information in your other plan documents may not apply to you.** We will send you a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Extra Help Rider"), which tells you about your drug coverage. If you are getting Extra Help and you don't have the insert, please call Customer Service and ask for the Extra Help Rider. Phone numbers for Customer Service are listed on the back of your member ID card and on the cover of this document.

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

In some situations, your plan premium could be more than the amount charged by your former employer or retiree group. These situations are described below.

- Some members are required to pay a **late enrollment penalty (LEP)** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the LEP may be added to the monthly plan premium. If so, their monthly premium will be the monthly plan premium, plus the amount of their LEP.
    - If you are required to pay the LEP, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. **Chapter 4, Section 9** explains the LEP.

- If you have an LEP and do not pay it, or it is not paid on your behalf, you could be disenrolled from the plan.

  Currently, the Commonwealth of Virginia Retiree Health Benefits Program does not collect an LEP, but if you have any LEP, it should still be resolved so that you do not pay a higher premium if you elect a Medicare Part D plan outside of the state program. The Commonwealth of Virginia Retiree Health Benefits Program can assist in resolving an LEP if the creditable coverage was under another state plan. Correspondence regarding an LEP will include additional information.

Many members are required to pay other Medicare premiums

In addition to paying your monthly plan premium, some members may be required to pay other Medicare premiums. Some plan members may pay a premium for Medicare Part A and some plan members may pay a premium for Medicare Part B, in addition to paying the monthly Part D plan premium.

Some people pay an extra amount for Part D because of their yearly income. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, you must pay an extra amount directly to the government (not this plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you <u>will</u> be disenrolled from the plan and you will lose your prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not this plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to **Chapter 4, Section 10.** You can also visit https://www.medicare.gov on the Web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Or you may call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.

Your copy of *Medicare & You* 2018 gives information about the Medicare premiums in the section called "2018 Medicare Costs." This explains how the Part D premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You* 2018 from the Medicare website (https://www.medicare.gov). Or you can order a printed copy by phone at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users call 1.877.486.2048.

Section 4.2 Can your former employer or your retiree group change your monthly plan premium during the year?

No. Your former employer or your retiree group is not allowed to change the amount it charges for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, you will be notified of the change in the fall and the change will take effect on January 1.

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for, or lose your eligibility for, the Extra Help program during the year. If a member qualifies for Extra Help with his or her prescription drug costs, the Extra Help program will pay part of the member's monthly plan premium. A member who loses his or her eligibility during the year will

need to start paying his or her full monthly premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover. You can find out more about the Extra Help program in **Chapter 4, Section 11.**

SECTION 5 Please keep your plan membership record up to date

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

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

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

Let us know about these changes:

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

If your name, address or phone number changes, please let us know by calling your group benefits administrator. To update other coverage, see below.

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

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

That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see **Section 7** in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct and complete, you don't need to do anything. If the information is incorrect or incomplete, or if you have other coverage that is not listed, please call the number noted in the letter you receive to provide us with the correct information to coordinate your benefits. If you have questions about who pays first, or you need to update your other insurance information, call Medicare's Benefit Coordination & Recovery Center (BCRC) toll free at 1.855.798.2627, Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users should call 1.855.797.2627.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

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

SECTION 7 How other insurance works with our plan

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

When you have other insurance (like employer group health coverage in addition to this plan), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for a former employer or retiree group health plan coverage:

- If you have coverage based on former employment, Medicare pays first.
- If you also have coverage based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your employer plan pays first if the employer has 100 or more employees, or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, the employer plan pays first if the employer has 20 or more employees, or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare unless you were already designated as Medicare primary when you became eligible due to ESRD.

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, employer group health plans, and/or Medigap have paid.

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

Chapter 2. Important phone numbers and resources

SECTION 1 Express Scripts Medicare contacts
(how to contact us, including how to reach Express Scripts Medicare Customer Service)

How to contact Express Scripts Medicare Customer Service

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

Method	Customer Service – Contact Information
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card and the front of this document. Customer Service is available 24 hours a day, 7 days a week.
WRITE	Express Scripts Medicare P.O. Box 66535 St. Louis, MO 63166-6535
WEBSITE	**https://www.express-scripts.com**

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

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

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

There are two types of coverage decisions and appeals: administrative and clinical. An administrative coverage decision or appeal occurs when the issue involves a decision about whether a medication is covered or not and at what cost-sharing amount. A clinical coverage decision or appeal occurs when the issue involves a decision about a restriction on a specific medication.

Method	Initial Clinical Coverage Reviews (Including Prior Authorization Requests) for Part D Prescription Drugs – Contact Information
CALL	**1.844.374.7377 (1.844.ESI.PDPS)** Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.877.251.5896**
WRITE	Express Scripts Attn: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571
WEBSITE	**https://www.express-scripts.com**

Method	Clinical Appeals for Part D Prescription Drugs – Contact Information
CALL	**1.844.374.7377 (1.844.ESI.PDPS)** Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 8:00 p.m., Central Time.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 8:00 p.m., Central Time.
FAX	**1.877.251.5896**
WRITE	Express Scripts Attn: Medicare Clinical Appeals P.O. Box 66588 St. Louis, MO 63166-6588
WEBSITE	**https://www.express-scripts.com**

Method	Administrative Coverage Reviews and Appeals for Part D Prescription Drugs – Contact Information
CALL	**1.800.413.1328** Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 6:00 p.m., Central Time.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are Monday through Friday, 8:00 a.m. to 6:00 p.m., Central Time.
FAX	**1.877.328.9660**
WRITE	Express Scripts Attn: Medicare Administrative Appeals P.O. Box 66587 St. Louis, MO 63166-6587
WEBSITE	**https://www.express-scripts.com**

How to contact us when you are making a complaint about the quality of care you have received, waiting times, customer service, or other concerns

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

Method	Express Scripts Contact Information for Filing a Complaint
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card and the front of this document.
TTY	**1.800.716.3231** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.
FAX	**1.614.907.8547**
WRITE	Express Scripts Medicare Attn: Grievance Resolution Team P.O. Box 3610 Dublin, OH 43016-0307
MEDICARE WEBSITE	You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Method	Express Scripts Contact Information for Payment Requests
CALL	The phone numbers for Express Scripts Medicare Customer Service are listed on the back of your member ID card and the cover of this document.
FAX	**1.608.741.5483**
WRITE	Express Scripts Attn: Medicare Part D P.O. Box 14718 Lexington, KY 40512-4718
WEBSITE	**https://www.express-scripts.com**

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

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease, also called ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

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

Method	Medicare – Contact Information
CALL	1.800.MEDICARE, or 1.800.633.4227 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1.877.486.2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	https://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, doctors, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. This plan will not be included in the summary from Medicare since it is not available to the entire Medicare population. You can also use the website to tell Medicare about any complaints you have about Express Scripts Medicare: • **Tell Medicare about your complaint:** You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. You can call Medicare at the numbers above.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please refer to the SHIP listing located in the **Appendix** to find information about the SHIP in your state.

A SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans. However, they will not have information about this plan.

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

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. Please refer to the QIO listing located in the **Appendix** to find information about the QIO in your state.

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

You should contact the QIO if you have a complaint about the quality of care you have received. For example, you can contact the QIO if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

The Social Security Administration (SSA) is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security benefits, enrollment into Medicare is automatic. If you are not getting Social Security benefits, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you

have to pay the extra amount and you have questions about the amount, or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you inform Social Security.

Method	Social Security Administration – Contact Information
CALL	1.800.772.1213 Calls to this number are free. The SSA is available from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day, 7 days a week.
TTY	1.800.325.0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The SSA is available from 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday.
WEBSITE	https://www.ssa.gov

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

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

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

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

To find out more about Medicaid and its programs, contact the Medicaid agency in your state (contact information is located in the **Appendix**).

Chapter 3. Using the plan's coverage for your Part D prescription drugs

?

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

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs (SPAPs). For more information, see **Chapter 4, Section 11.**

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice entitled, "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Extra Help Rider"), which tells you about your drug coverage. If you don't have this notice and are receiving Extra Help, please call Customer Service and ask for the Extra Help Rider. (Note: The Extra Help Rider does not provide information on SPAP assistance.) Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

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

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, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* handbook.)

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

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either already accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions or your Part D claim will be denied. If you are unsure if any of your prescribers is qualified, ask your prescribers the next time you call or visit if they meet

this condition. If any do not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- You must use a network pharmacy to fill your prescription. (See **Section 2** of this chapter for more information.)
- Your drug must be on the plan's 2018 *Formulary (List of Covered Drugs).* We call it the Drug List for short. (See **Section 3** of this chapter for more information.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. (See **Section 3** of this chapter for more information.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's home delivery service

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

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

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, visit our website at **https://www.express-scripts.com** or call Customer Service (phone numbers are listed on the back of your member ID card and on the front of this document). You can also look in your *Pharmacy Directory.* If you don't have a copy of the *Pharmacy Directory* and you would like one, please call Customer Service. Choose whatever is easiest for you.

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 doctor or to have your prescription transferred to your new network pharmacy.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are listed on the back of your member ID card and the front of this document) or use the *Pharmacy Directory.* You can also find information on our website at **https://www.express-scripts.com**.

What if you need a specialty pharmacy?

Sometimes prescriptions must be filled at a specialty pharmacy. Specialty 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 are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC

pharmacies, which is typically the pharmacy that the LTC facility uses. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your LTC pharmacy is not in our network, please contact Customer Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations, or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialty pharmacy, visit our website at **https://www.express-scripts.com**, call Customer Service or look in your *Pharmacy Directory*.

Section 2.3 Using the plan's home delivery service

For certain kinds of drugs, you can use the plan's network home delivery service. Generally, the drugs available through home delivery are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's home delivery service are marked as **mail-order drugs** (MO) in our Drug List.

To get order forms and information about filling your prescriptions by mail, either visit our website at **https://www.express-scripts.com** or call Customer Service at the numbers listed on the back of your member ID card and the front of this document.

Usually a home delivery pharmacy order will get to you within 10 days. However, sometimes your home delivery may be delayed. Make sure you have at least a 14-day supply of medication on hand. If you don't have enough, ask your doctor to give you a second prescription for a one-month supply and fill it at a retail network pharmacy while you wait for your home delivery supply to arrive. If your home delivery shipment is delayed, please call Customer Service at the numbers listed on the back of your member ID card and the front of this document.

New prescriptions the pharmacy receives directly from your doctor's office. After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 14 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.

Section 2.4 How can you get a maintenance supply of drugs?

When you get a maintenance supply of drugs, your cost-sharing amount may be lower. The plan offers two ways to get a long-term supply of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. They may accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept this lower cost-sharing amount. In this case, you will be responsible for the appropriate copayment or coinsurance for each (up to) 34-day supply. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at the numbers listed on the back of your member ID card and the front of this document for more information.
2. For certain kinds of drugs, you can use the plan's network **home delivery service. The drugs available through our plan's home delivery service are marked as "MO" (mail order) drugs in our Drug List.** See **Section 2.3** for more information about using our home delivery service.

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

Your prescription may be covered in certain situations

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

In a medical emergency. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

When traveling away from your local area. If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the back of your member ID card and the front of this document to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

To obtain a covered drug in a timely manner. In some cases, you may be unable to obtain a covered drug in a timely manner within your local area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy.

If a network pharmacy does not stock a covered drug. Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible retail network pharmacy or through our home delivery pharmacy service. We will cover prescriptions at an out-of-network pharmacy under these circumstances.

In these situations, **please check first with Express Scripts Medicare Customer Service** to see if there is a network pharmacy nearby. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

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

SECTION 3 The plan's Drug List

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

The plan has a 2018 *Formulary (List of Covered Drugs).* In this *Evidence of Coverage,* **we call it the Drug List for short.** The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets requirements set by Medicare and has been approved.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, **Section 1.1** explains about Part D drugs).

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

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

The Drug List includes both brand-name and generic drugs

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

What is *not* on the Drug List?

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

Section 3.2 How can you find out if a specific Part D drug is covered by the plan?

You have two ways to find out:

1. Check the most recent Drug List online at **https://www.express-scripts.com**.

2. Call Customer Service to find out if a particular drug is covered by the plan. Phone numbers for Customer Service are listed on the back of your member ID card or the front of this document.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

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

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

Section 4.2 What kinds of restrictions?

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

Restricting brand-name drugs when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. In most cases, when a generic version of a brand-name drug is available, our network pharmacies will provide you with the generic version. We usually will not cover the brand-name drug when a generic version is available. However, if your doctor has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug. (Your share of the cost will usually be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor needs to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization.** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

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

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document) or check our website at **https://www.express-scripts.com**.

If there is a restriction for your drug, it usually means that you or your doctor will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your doctor would need to do to get coverage for the drug. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See **Chapter 7, Section 5.2** for information about asking for exceptions.)

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

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

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

The drug might not be covered at all. Or maybe a generic version of the drug is covered, but the brand-name version you want to take is not covered.

The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in **Section 4,** some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.

The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. The plan puts covered drugs into different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

- If your drug is restricted, go to **Section 5.2** to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to **Section 5.2** to learn what you can do.

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

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

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

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

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

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer covered by the plan.**
- – *or* – the drug you have been taking is **now restricted in some way** (**Section 4** in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year and aren't in a long-term care (LTC) facility:** We will cover a temporary supply of a drug that you took during the prior plan year **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year.** This temporary supply will be for at least 30 days, or less if your prescription is written for fewer days. In that case, you will be allowed multiple fills to provide up to a total of at least a 30-day supply of the medication. The prescription must be filled at a network pharmacy.
- **For those members who are new or were in the plan last year and reside in an LTC facility:** We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year.** The total supply will be for a maximum of a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply

of medication. (Please note that the LTC pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those who have been a member of the plan for more than 90 days and reside in an LTC facility and need a supply right away:**
  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above LTC transition supply.

Other times when we will cover at least a temporary 30-day transition supply (or less if you have a prescription written for fewer days) include:

- When you enter an LTC facility
- When you leave an LTC facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

To ask for a temporary supply, call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document).

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

You can change to another drug

Start by talking with your doctor. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor find a covered drug that might work for you. (Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document.)

You can ask for an exception

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

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

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

Section 6.1 Your drug coverage can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to its drug coverage. For example, the plan might:

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

In almost all cases, we must get approval from Medicare for changes we make to the plan's drug coverage.

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

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

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

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

Do changes to your drug coverage affect you right away?

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

- If we move your drug into a higher cost-sharing tier
- If we put a new restriction on your use of the drug
- If we stop covering a drug, but not because of a sudden recall or because a new generic drug has replaced it

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

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

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

- Your doctor will also know about this change and can work with you to find another drug for your condition.

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

Section 7.1 Types of drugs we do not cover

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

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D, and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to **Chapter 7, Section 5.5.**)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label, as approved by the FDA.
  - Generally, coverage for off-label use is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its off-label use.

Also, by law, the following categories of drugs are not covered by Medicare Part D plans. However, see your plan materials to find out if your former employer or your retiree group provides additional coverage of some of these drugs. Please call Customer Service for drug coverage specifics.

- Drugs when used for anorexia, weight loss, or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs).
- Drugs, such as CAVERJECT®, CIALIS®, EDEX®, LEVITRA®, MUSE®, and VIAGRA®, when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR®, XELODA®)
- Non-prescription drugs, also known as over-the-counter (OTC) drugs.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. Please refer to your formulary or call Customer Service for more information. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document.

If you receive Extra Help paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in the **Appendix.**)

SECTION 8 Show your member ID card when you fill a prescription

Section 8.1 Show your member ID card

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

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

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

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

SECTION 9 Part D drug coverage in special situations

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

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that explain the rules for getting drug coverage.

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

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

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

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

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document.

What if you're a resident in an LTC facility and become a new member of the plan?

If you need a drug that is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for at least 30 days, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If needed, we will cover additional refills during your first 90 days in the plan.

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

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

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

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

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

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

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

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our 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.

If you have a Medigap plan and need to cancel your Commonwealth of Virginia plan coverage, contact your Benefits Administrator. (Your enrollment in this plan may automatically cancel any other Medicare prescription drug coverage in which you are enrolled.) Since all Commonwealth of Virginia Retiree Health Benefits Program Medicare-Coordinating Plans provide Medicare supplemental coverage and exclude any services received through a Medicare Advantage plan, you should carefully consider the value of other Medicare supplemental coverage in addition to your state plan coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a different Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator. (You do not need a notice for this plan since it is approved by Medicare.)

Section 9.5 What if you are in Medicare-certified Hospice?

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

Section 10.2 A program to help members manage their medications

We have a Medication Therapy Management (MTM) program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. The program can help make sure that our members get the most benefit from the drugs they take.

A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

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

If this program fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about this program, please contact Customer Service (phone numbers are listed on the back of your member ID card and the front of this document).

Chapter 4. Paying for your Part D prescription drugs

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

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs (SPAPs). For more information, see **Section 11** of this chapter.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** Please review the notice entitled, "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Extra Help Rider"), which tells you about your drug coverage. If you don't have this notice and are receiving Extra Help, please call Customer Service and ask for the Extra Help Rider. (Note: The Extra Help Rider does not provide information on SPAP assistance.) Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document.

SECTION 1 Introduction

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

This chapter focuses on what you pay for your covered Part D prescription drugs at a network pharmacy. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in **Chapter 3,** not all drugs are Part D drugs — some drugs are covered under Medicare Part A or Part B and other drugs are excluded by law from Medicare coverage.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Examples of some of the materials where you can find more information about your specific plan include the *Annual Notice of Changes for 2018,* the *Benefit Overview,* the *Quick Reference Guide,* and any notices you receive from us about changes to your coverage or conditions that affect your coverage.

Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. **Chapter 3** also tells which types of prescription drugs are not covered by our plan.

The plan's *Pharmacy Directory.* In most situations, you must use a network pharmacy to get your covered drugs (see **Chapter 3** for the details). The *Pharmacy Directory* has a list of the closest retail pharmacies in the plan's network based on your address of record, as well as other pharmacies in the network. It also explains how you can get a maintenance supply of a drug (such as filling a prescription for a three-month supply).

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

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

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on the plan selected by your former employer or your retiree group and which drug payment stage you are in when you get the drug

Section 2.1 What are the standard Part D drug payment stages?

As shown in the following table, there are typically four drug payment stages for your prescription drug coverage. The plan selected by your former employer or retiree group will determine if your plan has a Deductible or Coverage Gap stage and how these stages will apply (your *Benefit Overview* and other plan materials have more details). Not everyone reaches all stages in a plan year. Which stage you reach depends on how much you and the plan pay for covered drugs during the year.

How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind, you are always responsible for the plan's monthly premium, regardless of the drug payment stage you are in.

NOTE: Check your *Benefit Overview* or *Annual Notice of Changes* to see if your former employer or your retiree group has an annual prescription drug out-of-pocket maximum. If so, you may pay a reduced cost or pay nothing once you reach that annual out-of-pocket maximum amount.

STAGE 1 *Yearly Deductible stage*	**STAGE 2** *Initial Coverage stage*	**STAGE 3** *Coverage Gap stage*	**STAGE 4** *Catastrophic Coverage stage*
If your plan has a deductible, you begin in this stage when you fill your first prescription of the plan year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid the deductible listed in your *Benefit Overview* or *Annual Notice of Changes.* (More information on this stage is in **Section 4** of this chapter.)	During this stage, after you (or others on your behalf) have met your deductible, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** Your share of the cost is shown in your *Benefit Overview* or *Annual Notice of Changes.* You stay in this stage until your year-to-date **"total drug costs"** for covered drugs (your payments plus any Part D plan's payments) total $3,750. (More information on this stage is in **Section 5** of this chapter.)	Refer to your *Benefit Overview* or *Annual Notice of Changes* to determine if your plan has a Coverage Gap and what you and the plan will pay during this stage. You stay in this stage until your year-to-date **out-of-pocket costs** (your payments) reach a total of $5,000. This amount and rules for counting costs toward this amount have been set by Medicare. (More information on this stage is in **Section 6** of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year (through December 31, 2018). (More information on this stage is in **Section 7** of this chapter.)

SECTION 3 We will send you a Part D *Explanation of Benefits* (Part D EOB) which explains payments for your drugs and which payment stage you are in

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

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

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

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

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows your total drug cost, including what the plan paid and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs for the year since the year began.

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

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

- **Show your member ID card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your member ID card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions, go to **Chapter 5, Section 2.**) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchased a covered drug at a network pharmacy at a special price or used a discount card that was not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for the Catastrophic Coverage stage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are listed on the back of your member ID card and the front of this document). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 If the Deductible stage applies to your former employer or your retiree group plan, you pay the full cost of your drugs during this stage

Section 4.1 If your plan has a Deductible stage, you stay in this stage until you have paid the amount listed in your *Benefit Overview* or *Annual Notice of Changes*

If your plan does not have a deductible, please skip to Section 5.

The Deductible stage is the first payment stage for your drug coverage. It begins when you fill your first applicable prescription of the plan year. You will pay a yearly deductible in the amount listed in your *Benefit Overview* or *Annual Notice of Changes.* When you are in this payment stage, **you must pay the full cost of your drugs that apply to your deductible** until you reach the plan's deductible amount. Please refer to your *Benefit Overview* or *Annual Notice of Changes* to determine the amount of your deductible and to which types of drugs your deductible applies (in this plan, it only applies to covered brand-name drugs, not generics).

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

Once you have paid the applicable deductible, you leave the Deductible stage and move on to the next drug payment stage, which is the Initial Coverage stage.

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

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

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

Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's home delivery pharmacy

For more information about these pharmacy choices and filling your prescriptions, see **Chapter 3** and the plan's *Pharmacy Directory.*

Generally, we will cover your prescriptions only if they are filled at one of our network pharmacies.

Section 5.2 Your costs for covered Part D drugs

During the Initial Coverage stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **Copayment** means that you pay a fixed amount each time you fill a prescription.
- **Coinsurance** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in other plan documents you have received, the amount of the copayment or coinsurance also depends on which tier your drug is in.

- If your covered drug costs less than the copayment amount listed in your *Benefit Overview* or *Annual Notice of Changes,* you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower.*
- We cover prescriptions filled at out-of-network pharmacies only in limited situations. Please see **Chapter 3, Section 2.5** for information about when we will cover a prescription filled at an out-of-network pharmacy.

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

Typically, the amount you pay for a prescription drug (a copayment or coinsurance) covers a full month's supply (up to a 34-day supply) of a covered drug. However, your doctor can prescribe less than a full month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a full month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount). Daily cost-sharing under this plan applies as follows:

- A Tier 1 or Tier 2 drug: Since you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- A Tier 3 or Tier 4 drug: Since you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will generally be lower if you get less than a full month's supply, the *amount* you pay will be less.

Here's an example:

- Let's say the copayment for your drug for a full month's supply (a 34-day supply) is $34. This means that the amount you pay per day for your drug is $1. If you receive a 7-day supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total copayment of $7.

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

Section 5.4 You stay in the Initial Coverage stage until your total drug costs for the year reach $3,750

You stay in the Initial Coverage stage until the total amount for the prescription drugs you have filled and refilled reaches the **$3,750 limit for the Initial Coverage stage.**

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the plan year. (See **Section 6.2** for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The deductible you paid when you were in the Deductible stage (if applicable).
  - The total you paid (including amounts paid on your behalf) as your share of the cost for your drugs during the Initial Coverage stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage stage. (If you were enrolled in a different Part D plan at any time during 2018, the amount that plan paid during the Initial Coverage stage also counts toward your total drug costs.)

The Part D *Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $3,750 limit in a year.

If you do reach this amount, we'll let you know. You will leave the Initial Coverage stage and move on to the Coverage Gap stage.

Please refer to your *Benefit Overview* or *Annual Notice of Changes* for your plan-specific coverage in the Initial Coverage stage.

If your plan does not have a Coverage Gap stage, you will remain in the Initial Coverage stage until your total out-of-pocket costs reach $5,000. Once you reach this amount, you will move into the Catastrophic Coverage stage.

SECTION 6 Refer to your *Benefit Overview* or *Annual Notice of Changes* to see what you pay and what the plan pays during the Coverage Gap stage

Section 6.1 You stay in the Coverage Gap stage until your out-of-pocket costs reach $5,000

When you are in the Coverage Gap stage, **you pay what is shown in your *Benefit Overview* or *Annual Notice of Changes*** for this stage until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2018, that amount is $5,000.

Please refer to your *Benefit Overview* or *Annual Notice of Changes* to determine if your plan has a Coverage Gap stage. If your plan does have a Coverage Gap stage, your *Benefit Overview* or *Annual Notice of Changes* will indicate if any additional coverage is provided while in this stage.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D enrollees who have a total drug cost of $3,750 and are not receiving Extra Help. This total drug cost amount provides access to the discount program even if your plan does not have a Coverage Gap stage that results in your paying the full cost of your drugs. For brand-name drugs, manufacturers provide a 50% discount on the negotiated price (excluding the dispensing fee, if any). (Drugs manufactured by non-participants are not Part D drugs.) Once the manufacturer discount is applied, you pay your designated copayment or coinsurance (or the balance of the cost, if applicable) and a portion of the dispensing fee, and the plan pays the rest.

If you reach the Coverage Gap, we will automatically apply the discount when your pharmacy charges you for your prescription, and your Part D EOB will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the Coverage Gap. The amount paid by the plan (15%) does not count toward your out-of-pocket costs.

You also usually pay the same copayment for generic drugs in the Coverage Gap that you received in the Initial Coverage stage, except that in 2018 you will pay no more than 44% of the drug cost. The coverage for generic drugs works differently than the 50% discount for brand-name drugs. For generic drugs, the amount paid by the plan does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the Coverage Gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are listed on the back of your member ID card and the front of this document).

See your *Benefit Overview* or *Annual Notice of Changes* for the specifics of your coverage during the Coverage Gap stage.

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

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

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

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

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

It matters who pays:

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

Payments made by the Medicare Coverage Gap Discount Program are included. Since the Medicare Coverage Gap Discount Program does not cover generics, the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage stage:

When you (or those paying on your behalf) have spent a total of $5,000 in out-of-pocket costs within the calendar year, you will move on to the Catastrophic Coverage stage.

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

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

- Any premium cost
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments made by the plan during the Coverage Gap stage
- Payments for your drugs that are made by group health plans, including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and the Veterans Administration
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, workers' compensation)

Reminder: If any other organization, such as the ones listed above, pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are listed on the back of your member ID card and the front of this document).

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

- **We will help you.** The Part D *Explanation of Benefits* (Part D EOB) summary we send to you includes the current amount of your out-of-pocket costs (**Section 3** in this chapter tells about this report). When you reach a total of $5,000 in out-of-pocket costs for the year, this report will tell you that you have moved on to the Catastrophic Coverage stage.
- **Make sure we have the information we need. Section 3.2** tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

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

You qualify for the Catastrophic Coverage stage when your out-of-pocket costs have reached the $5,000 limit for the calendar year. Once you are in the Catastrophic Coverage stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - *–either –* coinsurance of 5% of the cost of the drug
  - *–or –* a $3.35 copayment for a generic drug or a drug that is treated like a generic. Or an $8.35 copayment for all other drugs.
- **Our plan pays the rest** of the cost.

The amounts above are the standard Medicare Part D cost-sharing amounts. Please refer to your *Benefit Overview* or *Annual Notice of Changes* to determine if your plan-specific coverage varies. In rare circumstances, your out-of-pocket cost during the Catastrophic Coverage stage could be more than you paid in the Initial Coverage and Coverage Gap stages.

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage of a number of Part D vaccines. There are two parts to our coverage of vaccinations:

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

What do you pay for a Part D vaccination?

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

1. **The type of vaccine** (what you are being vaccinated for)
   - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's 2018 *Formulary (List of Covered Drugs).*
   - Other vaccines are considered medical benefits. They are covered under Original Medicare.

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

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

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

To show how this works, here are three common ways you might get a Part D vaccine. Your actual costs may vary in each stage, depending on your plan design.

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

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

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

- When you get the vaccine, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in **Chapter 5** *(Asking us to pay our share of the costs for covered drugs)*.
- You will be reimbursed the amount you paid, less your normal coinsurance or copayment for the vaccine and administration.

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

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

Section 8.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We're here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are listed on the back of your member ID card and the front of this document).

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

SECTION 9 Do you have to pay the Part D late enrollment penalty (LEP)?

Section 9.1 What is the Part D LEP?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the LEP rules do not apply to you. You will not pay an LEP, even if you have gone without "creditable" prescription drug coverage.

You or your former employer or your retiree group may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage, or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

The penalty may be added to your monthly premium. When you first enroll in Express Scripts Medicare, we let you know the amount of the penalty. If you are responsible for an LEP, it is considered to be part of your plan premium for as long as you have Part D coverage. In this plan at this time, you will not be asked to pay an LEP, but in other plans, if your LEP is not paid, you could be disenrolled for failure to pay your plan premium. Your other plan materials will include additional information.

Section 9.2 How much is the Part D LEP?

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

- First count the number of full months that you delayed enrolling in a Medicare prescription drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare prescription drug plans in the nation from the previous year. For 2018, this average premium amount is $35.02. This amount may change for 2019.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $35.02, which equals $4.90. This rounds to $4.90. This amount would be added **to the monthly premium amount for someone with an LEP.**

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

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

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, there are times when you may not have to pay the LEP.

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this **creditable drug coverage.**
- Please note:
    - Creditable coverage could include drug coverage from a former employer or retiree group, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

  - For additional information about creditable coverage, please look in your *Medicare & You* 2018 handbook or call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 9.4 What can you do if you disagree about your LEP?

If you disagree about your LEP, you or your representative can ask for a review of the decision about your LEP. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay an LEP. Call Customer Service at the numbers listed on the back of your member ID card or on the front of this document to find out more about how to do this.

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

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

Most people will pay their plan's total monthly Part D premium. However, some people pay an extra amount because of their yearly income, which is called the Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA). If your income is $85,000 or above for an individual (or married filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless you don't have a monthly benefit or your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately. **This amount is not charged by this Part D plan, it is charged by the Federal government. It cannot be paid with your monthly premium for this plan.**

Section 10.2 How much is the extra Part D amount?

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

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

If you filed an individual tax return and your income in 2016 was:	If you were married but filed a separate tax return and your income in 2016 was:	If you filed a joint tax return and your income in 2016 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$13.00
Greater than $107,000 and less than or equal to $133,500		Greater than $214,000 and less than or equal to $267,000	$33.60
Greater than $133,500 and less than or equal to $160,000		Greater than $267,000 and less than or equal to $320,000	$54.20
Greater than $160,000	Greater than $85,000	Greater than $320,000	$74.80

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1.800.772.1213. Automated services are available 24 hours a day, 7 days a week. You can speak with a representative between 7 a.m. and 7 p.m., Eastern Time, Monday through Friday. TTY users should call 1.800.325.0778.

Section 10.4 What happens if you do not pay the extra Part D amount?

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

SECTION 11 Information about programs to help people pay for their prescription drugs

Medicare's Extra Help Program

Medicare provides Extra Help to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you may get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (the phone number is in the **Appendix**). Or call 1.800.MEDICARE (1.800.633.4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1.877.486.2048. You can also visit https://www.medicare.gov for more information.

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

- 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1.800.772.1213, between 7:00 a.m. and 7:00 p.m., Eastern Time, Monday through Friday. TTY users should call 1.800.325.0778 (applications); or
- Your State Medicaid Office (applications). (See the **Appendix** for contact information.)

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

We may be able to accept one of the following forms of Best Available Evidence (BAE) to establish that you qualify for Extra Help, when the evidence is provided by you or your pharmacist, advocate, representative, family member, or other individual acting on your behalf:

1. A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during any month after June of the previous calendar year;
2. A copy of a state document that confirms active Medicaid status during any month after June of the previous calendar year;
3. A printout from the state electronic enrollment file showing Medicaid status during any month after June of the previous calendar year;
4. A screen print from the state's Medicaid systems showing Medicaid status during any month after June of the previous calendar year;
5. Other documentation provided by the state showing Medicaid status during any month after June of the previous calendar year;
6. A letter from the Social Security Administration (SSA) showing that the individual receives Supplemental Security Income (SSI); or,
7. An Application Filed by Deemed Eligible confirming that the beneficiary is "…automatically eligible for extra help…" (SSA publication HI 03094.605)

The following proofs of institutional status are acceptable from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member, or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized, beginning on a date specified by the Secretary of the Department of Health and Human Services (HHS):

1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during any month after June of the previous calendar year;
2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
3. A screen print from the state's Medicaid systems showing that individual's institutional status based on at least a full calendar-month stay for Medicaid payment purposes during any month after June of the previous calendar year.

The following proofs of status are acceptable from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member, or other individual acting on behalf of the beneficiary to establish that an individual is receiving home and community-based services (HCBS) and qualifies for zero cost-sharing effective as of a date specified by the Secretary of HHS:

1. A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
2. A State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
3. A State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;
4. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,
5. A State-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

You or your representative may fax or mail Best Available Evidence to the following fax number or address:

Fax: **1.855.297.7271**
Address: **Express Scripts Medicare (PDP)**
P.O. Box 4558
Scranton, PA 18505

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service at the numbers on the front of this document if you have questions.

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

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand-name drugs in the Coverage Gap stage. The 50% discount and the 15% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?
The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription drug cost-sharing assistance in those states that have this program. Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the State, and uninsured/underinsured status.

If you are currently enrolled in an ADAP, it may continue to provide you with Medicare Part D prescription drug cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. For information on eligibility criteria, covered drugs, or how to enroll in the program, please refer to the contact information located in the **Appendix.**

What if you get Extra Help from Medicare to help pay your prescription drug costs?
Can you get the discounts from the Coverage Gap Discount Program?

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

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

If you think that you have reached the Coverage Gap and did not get a discount when you paid for your brand-name drug, you should review your next Part D *Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your Part D EOB, you should contact us to make sure that your prescription records are correct and up to date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in the **Appendix**) or by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

State Pharmaceutical Assistance Programs (SPAPs)

Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members. Contact information for SPAPs is located in the **Appendix.**

Chapter 5. Asking us to pay our share of the costs for covered drugs

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

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

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

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

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

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

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

2. When you pay the full cost for a prescription because you don't have your member ID card with you

If you do not have your member ID card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the plan to get your member information, but there may be times when you need to pay if you do not have your member ID card.

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

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's Drug List, or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.
- If you are requesting payment for coverage of a Part D vaccine, such as a vaccine drug or administration of a vaccine drug, please save your invoice (bill) from your doctor and send a copy to us when you ask us to pay you back for our share of the cost.

- In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan

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

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

- Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document.

5. In a medical emergency

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When traveling away from your local area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our home delivery pharmacy service. If you are traveling within the United States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Customer Service numbers listed on the back of your member ID card and the front of this document to find out if there is a network retail pharmacy in the area where you are traveling. If there are no network pharmacies in that area that can dispense your drug, Customer Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled outside the United States, even for a medical emergency.

7. To obtain a covered drug in a timely manner

In some cases, you may be unable to obtain a covered drug in a timely manner within your local area. If there is no network pharmacy within a reasonable driving distance that provides 24-hour service, we will cover your prescription at an out-of-network pharmacy. Save your pharmacy prescription receipt and send a copy to us when you ask us to pay you back for our share of the cost.

8. If a network pharmacy does not stock a covered drug

Some covered prescription drugs (including orphan drugs or other specialty pharmaceuticals) may not be regularly stocked at an accessible retail network pharmacy or through our home delivery pharmacy. We will cover prescriptions at an out-of-network pharmacy under these circumstances. Save your

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. **Chapter 7** has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

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

Send us your request for payment, along with a copy of your pharmacy prescription receipt or your pharmacy patient history printout signed by the dispensing pharmacist. A copy of an invoice (bill) is required for all other requests for payment, such as claims for vaccines from a physician or claims for Medicare Part D drugs from a hospital or clinic. It's a good idea to keep the original receipts or invoices, or to make copies, for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website, **https://www.express-scripts.com**, or call Customer Service and ask for a "Direct Claim Form." The phone numbers for Customer Service are listed on the back of your member ID card and the front of this document.

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

Express Scripts
Attn: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

You also have the option of faxing your claim form and receipts to **1.608.741.5483.**

You must submit your claim to us within 36 months of the date you received the service, item or drug.

Please be sure to contact Customer Service if you have any questions. Phone numbers for Customer Service are listed on the back of your member ID card and the front of this document. If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (**Chapter 3** explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 14 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested, and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The examples of situations in which you may need to ask our plan to pay you back:

- When you use an out-of-network pharmacy to get a covered prescription filled
- When you pay the full cost for a covered prescription because you don't have your member ID card with you
- When you pay the full cost for a prescription in other situations

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

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

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

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

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

1. **When you buy the drug for a price that is lower than our price**
   Sometimes when you are in the Deductible stage and/or Coverage Gap stage (if they apply to your plan), you may be able to buy your drug **at a pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your qualifying out-of-pocket expenses count toward the Catastrophic Coverage stage.
- **Please note:** If you are in the Deductible stage and/or Coverage Gap stage (if they apply to your plan and the plan does not provide coverage in the gap), we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and will count toward qualifying for the Catastrophic Coverage stage.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and will count toward qualifying for the Catastrophic Coverage stage.

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

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, or in other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are listed on the back of your member ID card).

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. We can also give you information in braille or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits that is accessible and appropriate for you. To get information from us in a way that works for you, please call Express Scripts Medicare Customer Service at the numbers on the back of your member ID card or contact our Civil Rights Coordinator at:

Express Scripts Medicare
P.O. Box 4083
Dublin, Ohio 43016

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1.800.MEDICARE (1.800.633.4227), or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact us at the numbers located on the back of your member ID card for additional information.

Sección 1.1 Debemos proporcionar información de manera que funcione para usted (en idiomas que no sean inglés, en Braille o en formatos alternativos, etc.)

Para obtener información de parte nuestra de manera que funcione para usted, llame al Servicio al Cliente (los números de teléfono aparecen en el reverso de su tarjeta de identificación de miembro).

Nuestro plan tiene personas y servicios de interpretación gratuitos que están disponibles para responder las preguntas de miembros con discapacidades y que no hablan inglés. También podemos brindarle información en Braille u otros formatos alternativos sin costo, en caso de que lo necesite. Debemos brindarle información acerca de los beneficios del plan de manera accesible y adecuada para usted. Para obtener información de parte nuestra de manera que funcione para usted, llame al Servicio al cliente de Express Scripts Medicare a los números de teléfono que aparecen en el reverso de su tarjeta de identificación de miembro o comuníquese con nuestro Coordinador de Derechos Civiles en:

Express Scripts Medicare
P.O. Box 4083
Dublin, Ohio 43016

Si tiene alguna dificultad para recibir información de nuestro plan debido a problemas relacionados con el idioma o con una discapacidad, llame a Medicare al 1.800.MEDICARE (1.800.633.4227) o comuníquese directamente con la Oficina de Derechos Civiles. Puede encontrar información de contacto en esta Evidencia de Cobertura o en esta correspondencia, o puede comunicarse con nosotros a los números de teléfono que aparecen en el reverso de su tarjeta de identificación de miembro para obtener información adicional.

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

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 for recorded information (TTY users, call 1.800.537.7697). You can also visit their website at https://www.hhs.gov/ocr/ or contact your regional Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are listed on the back of your member ID card and the front of this document). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

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

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

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

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

- Your personal health information includes the personal information we received when you enrolled in this plan, as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice in your initial Welcome Kit, called a *Notice of Privacy Practices,* that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.

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

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

You have the right to look at your medical records held by the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your doctor to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document).

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

As a member of Express Scripts Medicare, you have the right to get several kinds of information from us. (As explained in **Section 1.1,** you also have the right to get information from us in a way that works for you. This includes getting the information in languages other than English, in braille, or in other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document):

- **Information about our plan**

  This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members.
- **Information about our network pharmacies**
    - For example, you have the right to get information from us about the pharmacies in our network.
    - For a list of the retail pharmacies in your area and others that are in the plan's network, see the *Pharmacy Directory.*
    - For more detailed information about our pharmacies, you can call Customer Service

(phone numbers are listed on the back of your member ID card and the front of this document) or visit our website at **https://www.express-scripts.com**.

- **Information about your coverage and rules you must follow in using your coverage**
  - To get the details on your Part D prescription drug coverage, see **Chapters 3** and **4.** These chapters, together with the 2018 *Formulary (List of Covered Drugs)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document).
- **Information about why something is not covered and what you can do about it**
  - If your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are dissatisfied with your plan, or if you disagree with a decision we make about how a Part D drug is covered for you, you have the right to make an appeal and ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see **Chapter 7.** It gives you the details about how to make an appeal if you want us to change our decision. (**Chapter 7** also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see **Chapter 5.**

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

You have the right to give instructions about what is to be done if you become unable to make medical decisions for yourself

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

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

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the appropriate agency in your state, such as the Department of Health.

Many advance directives only delegate authority if you are determined to be unable to make your own health care decisions. If you are not determined to be unable to make your own decisions, the designee does not have authority to make decisions on your behalf.

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

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

As explained in **Chapter 7,** what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document).

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

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

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 for recorded information (TTY users, call 1.800.537.7697). You can also visit their website at https://www.hhs.gov/ocr/ or contact your regional Office for Civil Rights.

Is it about something else?

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

- You can **call Customer Service** (phone numbers are listed on the back of your member ID card and the front of this document).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to **Chapter 2;** for information on how to contact it, go to the **Appendix.**
- Or **you can call Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Section 1.9 How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are listed on the back of your member ID card and the front of this document).
- You can **call the State Health Insurance Assistance Program.** For details about this organization, go to **Chapter 2;** for information on how to contact it, go to the **Appendix.**
- You can contact **Medicare.**
    - You can visit the Medicare website to read or download the publication, "Your Medicare Rights and Protections." (The publication is available at: https://www.medicare.gov/Pubs/pdf/11534.pdf.)
    - Or you can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document). We're here to help.

- ***Get familiar with your covered drugs and the rules you must follow to get these covered drugs.*** *Use this* Evidence of Coverage *and other plan documents you have received to learn what's covered for you and the rules you need to follow to get your covered drugs.*
    - **Chapters 3** and **4** give the details about your coverage for Part D prescription drugs.

- ***If you have any other prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call Customer Service to let us know (phone numbers are listed on the back of your member ID card and the front of this document).*
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called **coordination of benefits** because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to **Chapter 1, Section 7.)**

- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your member ID card whenever you get your Part D prescription drugs.*

- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
    - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
    - If you are responsible for a premium, you must pay it to continue being a member of this plan.
    - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) *or* coinsurance (a percentage of the total cost). Your *Benefit Overview* or *Annual Notice of Changes* will tell you what you must pay for your Part D prescription drugs.
    - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see **Chapter 7** for information about how to make an appeal.

  - In most Part D plans, if you are required to pay a late enrollment penalty (LEP), you must pay the penalty to remain a member of the plan.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the Federal Government to remain a member of the plan.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call your group benefits administrator.*
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (**Chapter 1** tells about our service area.)
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you. Contact your group benefits administrator to update your address.
  - If you move, it is also important to tell Social Security. You can find the phone numbers and contact information for Social Security in **Chapter 2.**

- ***Call Customer Service for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
  - Phone numbers and hours of operation for Customer Service are listed on the back of your member ID card and the front of this document.
  - For more information on how to reach us, including our mailing address, please see **Chapter 2.**

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Background

SECTION 1 Introduction

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

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

- One for **getting coverage decisions and making appeals**
- And another process **for making complaints**

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

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

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. You will find phone numbers in the **Appendix.**

You can also get help and information from Medicare

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

- You can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week.
  TTY users should call 1.877.486.2048.
- You can visit the Medicare website (https://www.medicare.gov).

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

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

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

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**	
Is your problem or concern about your benefits or coverage? (This includes problems about whether particular prescription drugs are covered or not, the way in which they are covered, and problems related to payment for prescription drugs.)	
Yes. My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4: A guide to the basics of coverage decisions and appeals.**	**No.** My problem is not about benefits or coverage. Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

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

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

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

Asking for coverage decisions

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

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is

handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

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

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

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

- You **can call us at Customer Service** (phone numbers are listed on the back of your member ID card and the front of this document).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see **Section 2** of this chapter for more information).
- **If your concern is about coverage of Part D prescription drugs,** your doctor or other prescriber can request a coverage decision or a Level 1 or 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other prescriber, or any other person to be your representative, call Customer Service (phone numbers for Customer Service are listed on the back of your member ID card and the front of this document) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The "Appointment of Representative" form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

Your benefits as a member of our plan include coverage for many prescription drugs. Please check the 2018 *Formulary (List of Covered Drugs)* online at **https://www.express-scripts.com**. To be covered, the drug must be must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain reference books. See **Chapter 3, Section 3** for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the 2018 *Formulary (List of Covered Drugs)*, rules and restrictions on coverage, and cost information, see **Chapter 3** and **Chapter 4.**

Part D coverage decisions and appeals

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

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

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

- You ask us to make an exception, including:
    - Asking us to cover a Part D drug that is not on the plan's 2018 *Formulary (List of Covered Drugs)*
    - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
    - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier

- You ask us not to enforce a coverage rule. (For example, when your drug is covered by the plan, but we require you to get approval from us before we will cover it for you.)
    - Please note: If your pharmacy tells you that your prescription cannot be covered as written, you will get a written notice from the pharmacy explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

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

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

Section 5.2 What is an exception?

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

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

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

Legal terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.**

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that is set by the plan. You cannot ask for another exception to the coinsurance amount we require you to pay for the drug.

- Generally, we cannot approve a request for coverage of any "excluded drugs," or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see **Chapter 3.**)

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs we cover (for more information, go to **Chapter 3**).

Legal terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for an **exception.**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand-name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called **prior authorization.**)
  - *Being required to try a different drug first* before we agree to cover the drug you are asking for. (This is sometimes called **step therapy.**)
  - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.

- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in a specific cost-sharing tier. You can see what tier a drug is in by checking your 2018 *Formulary (List of Covered Drugs*) online at **https://www.express-scripts.com**. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

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

- We may not be able to change the cost-sharing tier for any drugs in the Specialty tier.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our plan's coverage includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for a formulary or tiering exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say yes or no to your request

- If we approve your request for an exception, our approval is typically valid for 12 months. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. **Section 5.5** tells you how to make an appeal if we say no.

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

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

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

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your authorized representative, or your doctor (or other prescriber) can do this. You can also access information about the coverage decision process through our website. For the details, go to **Chapter 2, Section 1** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request asking us to pay for our share of the cost of a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. **Section 4** of this chapter tells how you can give written permission to someone else to act as your authorized representative. You can also give permission to a lawyer to act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading **Chapter 5**: *Asking us to pay our share of the costs for covered drugs.* **Chapter 5** describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the supporting statement.** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to 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. See **Sections 5.2** and **5.3** for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website at **https://www.express-scripts.com**.

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

Legal terms	A fast decision is called an **expedited coverage determination.**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast decision *only* if using *the standard deadlines could cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast decision, we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see **Section 7** of this chapter.)

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

Deadlines for a **fast** coverage decision

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

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

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

Deadlines for a **standard** coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.

  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

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

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

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

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

Legal terms	An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.**

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

What to do

- **To start your appeal, you (or your authorized representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail, for any purpose related to your appeal, go to **Chapter 2, Section 1,** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in **Chapter 2, Section 1** (*How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.*)
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone numbers shown in Chapter 2, Section 1** *(How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.)*
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information included in your appeal and add more information if needed.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

Legal terms	A fast appeal is also called an **expedited reconsideration.**

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

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

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

Deadlines for a **fast appeal**

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

Deadlines for a **standard appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal request.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal request.
    - If we approve a request to pay **you back for a drug** you already bought, we are required to **send payment to you within 30 calendar days after we receive** your appeal request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

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

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

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

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

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

Step 1 To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says 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 who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

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

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

Deadlines for **fast appeal** at Level 2

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

Deadlines for **standard appeal** at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
    - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
    - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

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

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

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

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D drug appeals

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

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

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

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

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

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

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

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

- This is the last step of the appeals process.

Making complaints

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

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

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

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

If you have any of the following kinds of problems or concerns, you can make a complaint:

- If you are unhappy with the quality of care received
- If you feel someone did not respect your right to privacy or has shared information you feel should be confidential
- If you feel someone treated you disrespectfully
- If you received poor customer service
- If you feel you are being encouraged to leave the plan
- If you were kept waiting too long at the pharmacy or by Customer Service
- If you are unhappy with the condition or cleanliness of the pharmacy
- If you feel we have not given you a notice we are required to give or that written information was too difficult to understand

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals:

The process of asking for a coverage decision and making appeals is explained in **Sections 4-6** of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.

- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

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

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

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

Section 7.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Call us at the phone numbers listed on the back of your member ID card and the front of this document.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
    - If you call to make a complaint, an attempt will be made to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we will respond within 30 days.
    - If you prefer to make your complaint in writing, please send a letter (or a complaint form, which can be obtained on our website, **https://www.express-scripts.com**, or you may request a form from Customer Service) with as much detail as possible to: Express Scripts Medicare, Attn: Grievance Resolution Team, P.O. Box 3610, Dublin, OH 43016-0307. All written complaints will be responded to within 30 days.
    - If you have a grievance regarding a denial for a request for a “fast coverage decision” or a “fast appeal,” we will give you an answer within 24 hours.
- **Whether you call or write, you should file your complaint right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a fast response to a coverage decision or appeal, we will automatically give you a fast complaint.**
  If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

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

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

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

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

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in the **Appendix.** If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

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

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1.800.MEDICARE (1.800.633.4227). TTY users can call 1.877.486.2048.

Chapter 8. Ending your membership in this plan

Note: This chapter contains general information on disenrollment from a Medicare Part D plan and member options. For specific options available to you as a member of a group sponsored plan or for more information, please contact your group benefits administrator.

SECTION 1 Introduction

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

Ending your membership in Express Scripts Medicare may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave this plan because you have decided to end your membership or you are no longer eligible.
    - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in many Medicare Part D plans. **Section 2** tells you *when* you can generally end your membership in some plans. **However, as a member of a group sponsored plan (such as this plan), you may end your membership at any time throughout the year and you will be granted a Special Enrollment Period to enroll in other coverage.**
    - The process for voluntarily ending your membership varies, depending on what type of new coverage you are choosing. **Section 3** tells *you how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. **Section 5** tells you about situations when we must end your membership.

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

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

As explained above, you can end your membership in this plan prospectively at any time. In many Medicare Part D plans, you may only end your membership during certain times of the year, known as enrollment periods. All members have the opportunity to leave their plan during the Medicare Annual Enrollment Period.

The remainder of Section 2 addresses Medicare Part D plans available to all Medicare beneficiaries and does not generally apply to this plan. Contact Customer Service if you have questions.

Section 2.1 Usually, you can end your membership during the Medicare Annual Enrollment Period

In some plans, you can only end your membership during the **Medicare Annual Enrollment Period** (also known as the Annual Coordinated Election Period). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year. In certain types of plans, you may also be eligible to leave the plan at other times of the year (see above).

- **When is the Medicare Annual Enrollment Period?** This happens from October 15 to December 7 every year. **Some employers or retiree groups may have established an open enrollment period with different timing during which you may elect changes. Please contact the appropriate group benefits administrator for more information about any former employer or your retiree group-established open enrollment periods. (This plan does not have an open enrollment period.)**
- **When will your membership end? If you enroll in other Part D coverage,** your membership in this plan will end when your new plan's coverage begins on January 1. If you enroll in another plan during this period, it will cause your second election to end.

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

In certain situations, Medicare beneficiaries may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period.** As a member of a group sponsored plan, you may end your membership in this plan at any time during the year and you will qualify for a Special Enrollment Period.

- **Who is eligible for a Special Enrollment Period?** For most Medicare Part D plans, you are eligible to end your membership during the Special Enrollment Periods listed below. These are just examples of special enrollment periods that are available. For the full list, you can contact the plan, call Medicare, or visit the Medicare website (https://www.medicare.gov):
    - If you have moved out of your plan's service area
    - If you have Medicaid
    - If you are eligible for Extra Help with paying for your Medicare prescriptions
    - If we violate our contract with you
    - If you are getting care in an institution, such as a nursing home or long-term care hospital
    - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). **Note:** PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service at the numbers located on the back of your member ID card.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage.

Section 2.3 Where can you get more information about ending membership in a Medicare prescription drug plan?

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

- You can **call Customer Service** (phone numbers are listed on the back of your member ID card and the front of this document).
- You can find the information in the *Medicare & You* 2018 handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (https://www.medicare.gov). Or you can order a printed copy by calling Medicare at the numbers below.
- You can contact **Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

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

You may request termination of this coverage by submitting an Enrollment/Disenrollment Form to your group benefits administrator. The effective date will be the first of the month after the form is received unless you stopped paying your premium and have exhausted your grace period before that date. If you enroll in another Part D plan, Medicare will terminate your coverage in this plan. Terminating just this plan will result in your enrollment in a Medical-Only plan that includes no prescription drug coverage. In order to cancel all participation in the State Retiree Health Benefits Program, you must submit a request to do so to your group benefits administrator unless you stop paying any premium.

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

Section 4.1 Until your membership ends, you are still a member of this plan

If you leave Express Scripts Medicare, it may take time before your membership ends and your new Medicare coverage goes into effect. (See **Section 2** for information on when your new coverage begins.) During this time, you should continue to get your prescription drugs through this plan as long as you remain eligible.

- **In order to have coverage through this plan until your new coverage starts, you should continue to pay your premium and use our network pharmacies to get your prescriptions filled until your membership in this plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our home delivery pharmacy services.

SECTION 5 Express Scripts Medicare must end your membership in certain situations

Section 5.1 When must we end your membership?

Express Scripts Medicare must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move out of or are away from our service area for more than 12 months.
  - If you move or take a long trip, you need to call Customer Service (phone numbers are listed on the back of your member ID card and the front of this document) to find out if the place you are moving or traveling to is in this plan's service area.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in this plan and that information affects your eligibility for this plan. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of this plan. (We cannot make you leave this plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get prescription drugs. (We cannot make you leave this 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 do not pay any plan premiums you are responsible for according to your group's premium payment policy.
  - The plan must notify you in writing that you have a grace period, which cannot be less than 2 calendar months, to pay the plan premium before we end your membership. Contact your group benefits administrator for more information about your plan premium and its grace periods for paying your plan premium.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare <u>will</u> disenroll you from this plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, you can call **Customer Service** (phone numbers are listed on the back of your member ID card and the front of this document).

Section 5.2 We cannot ask you to leave this plan for any reason related to your health

Express Scripts Medicare is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave this plan because of a health-related reason, you should call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in this plan

If we end your membership in this plan, we must tell you our reasons in writing for ending your membership. We must also explain how you file a grievance or how to make a complaint about our decision to end your membership. You can also look in **Chapter 7, Section 7** for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Express Scripts Medicare, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR, and the rules established in this section supersede any State laws.

Chapter 10. Definitions of important words

2018 *Formulary (List of Covered Drugs)* or **Drug List** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs. This list contains the most commonly used covered drugs and does not include all Part D drugs covered by this plan.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. **Chapter 7** explains appeals, including the process involved in making an appeal.

Brand-name drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage stage – The stage in the Part D drug benefit where you usually pay a lower copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $5,000 on covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. **Chapter 2** explains how to contact CMS.

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

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed copayment amount that a plan requires when a specific drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply (34-day supply) of certain drugs for you and you are required to pay a copayment.

Coverage determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the medication isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document. **Chapter 7** explains how to ask us for a coverage decision.

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

Creditable prescription drug coverage – Prescription drug coverage (for example, from an employer or retiree group) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later and have not experienced a 63 or more day break in creditable coverage.

Customer Service – A department within this plan responsible for answering your questions about your membership, benefits, and filing grievances. See the back of your member ID card and the front of this document for information about how to contact Customer Service.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $34 and a one-month's supply in your plan is 34 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for prescriptions before this plan begins to pay (if your plan has a deductible).

Disenroll or **Disenrollment** – The process of ending your membership in this plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Drug Tier (Cost-sharing Tier) – Each drug on our drug list is placed in a drug, or cost-sharing, tier – for example, Generic Drugs tier. The amount you pay as a copayment or coinsurance depends, in part, on which tier the drug is in. You can find more information about tiers in your 2018 *Formulary (List of Covered Drugs)*.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

***Evidence of Coverage* (EOC) and Disclosure Information** – This document, along with your eligibility record and any other attachments, riders, or enclosures, explains your Medicare drug coverage in general, what we must do, your rights, and what you have to do as a member of this Medicare prescription drug plan.

Exception – A type of coverage determination allowing you to request that a plan restriction or limit be waived for certain drugs. Examples include: allowing a different dosage or quantity of a drug, allowing you to use a drug without getting approval for it in advance, or allowing you to try a drug prescribed by your doctor that would normally require you to try a different drug first.

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.

Generic drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Initial coverage limit – The total drug cost under the Initial Coverage stage.

Initial Coverage stage – This is the stage after you have met your deductible (if any) and before your total drug expenses have reached $3,750, including amounts you've paid and what this plan has paid on your behalf. During this stage, you pay your share and the plan pays its share.

Late enrollment penalty (LEP) – An amount that may be added to your monthly premium for Medicare prescription drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See the **Appendix** for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration (FDA) or supported by certain reference books. See **Chapter 3, Section 3** for more information about a medically accepted indication.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease, also called ESRD (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) Plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In many cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage (MA-PD).** Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with ESRD (unless certain exceptions apply).

Medicare Annual Enrollment Period – A set time each fall when members can change their Medicare health or drug plans. The Medicare Annual Enrollment Period is from October 15 until December 7 every year.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a health maintenance organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the Coverage Gap stage or total drug costs (yours and the plan's) of $3,750 and who are not already receiving Extra Help. Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, covered brand-name drugs are discounted.

Medicare health plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare prescription drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Network pharmacy – A network pharmacy is a pharmacy where members of this plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with this plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the Federal government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with this plan to coordinate or provide covered drugs to members of this plan. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by this plan unless certain conditions apply.

Out-of-pocket costs – See the definition for "cost-sharing" at the beginning of this chapter. 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. Your out-of-pocket costs are what move you toward the Catastrophic Coverage stage.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D drugs – Drugs that can be covered under Part D. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs. Please check your 2018 *Formulary (List of Covered Drugs*) online at **https://www.express-scripts.com** or **Chapter 3** for more information on what drugs are covered by this plan.

Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior authorization – A type of plan restriction requiring approval in advance to get certain drugs on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See the **Appendix** for information about how to contact the QIO in your state.

Quantity limits – A type of plan restriction on certain drugs that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the plan's service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, if we violate our contract with you, or if you leave this plan.

Step Therapy – A type of plan restriction on certain drugs that requires you to first try another drug to treat your medical condition before we will cover the drug your doctor may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

AIDS Drug Assistance Programs TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
State:	**Agency:**	**Telephone Number:**
Alabama	Alabama AIDS Drug Assistance Program Alabama Department of Public Health HIV/AIDS Division, The RSA Tower 201 Monroe Street, Suite 1400 Montgomery, AL 36104	Toll-free: 1.866.574.9964
Alaska	State of Alaska Department of Health & Social Services Division of Public Health Section of Epidemiology, HIV/STD Program 3601 C Street, Suite 540 Anchorage, AK 99503	Local: 1.907.269.8000 Local: 1.907.263.2050
American Samoa	American Samoa Department of Health LBJ Tropical Medical Center Pago Pago, AS 96799	Local: 1.684.633.4071
Arizona	Arizona Department of Health Services 150 N. 18th Avenue, Suite 130 Phoenix, AZ 85007	Toll-free: 1.800.334.1540 Local: 1.602.364.3610
Arkansas	Arkansas Department of Health HIV/STD/Hepatitis C section – ADAP Division 4815 W. Markham, Slot 33 Little Rock, AR 72205	Toll-free: 1.888.499.6544 Local: 1.501.661.2408
California	Office of AIDS California Department of Public Health MS 7700, P.O. Box 997426 Sacramento, CA 95899-7426	Local: 1.916.449.5900
Colorado	Colorado Department of Public Health & Environment Care and Treatment Program ADAP-3800 4300 Cherry Creek Drive South Denver, CO 80246	Local: 1.303.692.2716
Connecticut	Connecticut AIDS Drug Assistance Program Department of Social Services Medical Operations Unit # 4 55 Farmington Avenue Hartford, CT 06105-3730	Toll-free: 1.800.233.2503
Delaware	Division of Public Health, HIV/AIDS Program Thomas Collins Building 540 S. DuPont Highway Dover, DE 19901	Local: 1.302.744.1050
District of Columbia	DC ADAP DC Department of Health 899 North Capitol Street, NE Washington, DC 20002	Local: 1.202.671.4900 TTY: 711

AIDS Drug Assistance Programs
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.

State:	Agency:	Telephone Number:
Florida	Florida Department of Health HIV/AIDS Section AIDS Drug Assistance Program 4052 Bald Cypress Way, BIN A09 Tallahassee, FL 32399	Toll-free: 1.800.352.2437 TTY: 1.888.503.7118
Georgia	Georgia Department of Public Health – ADAP 2 Peachtree Street, NW, 15th Floor Atlanta, GA 30303-3186	Local: 1.404.657.2700
Guam	Department of Public Health and Social Services Bureau of Communicable Disease Control STD/HIV Program, Room 156 123 Chalan Kareta Mangilao, GU 96913	Local: 1.671.735.7166
Hawaii	Hawaii Department of Health Harm Reduction Services Branch HIV Medical Management Services 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816	Local: 1.808.733.9360
Idaho	Idaho Ryan White Part B Program 450 West State Street P.O. Box 83720 Boise, ID 83720-0036	Local: 1.208.334.5612
Illinois	Illinois Department of Public Health Illinois ADAP Office 525 W. Jefferson Street, 1st Floor Springfield, IL 62761	Local: 1.217.782.4977 TTY: 1.800.547.0466
Indiana	Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204	Toll-free: 1.866.588.4948
Iowa	Iowa Department of Public Health 321 East 12th Street Des Moines, IA 50319-0075	Local: 1.515.281.7689 TTY: 711
Kansas	Kansas Department of Health & Environment 1000 South West Jackson, Suite 210 Topeka, KS 66612	Local: 1.785.296.6174
Kentucky	Kentucky Department for Public Health Cabinet for Health and Family Services 275 East Main Street Frankfort, KY 40621	Toll-free: 1.866.510.0005
Louisiana	Louisiana Office of Public Health Louisiana Health Access Program 1450 Poydras Street, Suite 2136 New Orleans, LA 70112	Local: 1.504.568.7474

AIDS Drug Assistance Programs
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.

State:	Agency:	Telephone Number:
Maine	Maine Center For Disease Control and Prevention ADAP 40 State House Station Augusta, ME 04330-9758	Local: 1.207.287.3747 TTY: 711
Maryland	Maryland Department of Health and Mental Hygiene Maryland AIDS Drug Assistance Program (MADAP) 201 West Preston St. Baltimore, MD 21201-2399	Toll-free: 1.800.205.6308 Local: 1.410.767.6535 TTY: 1.800.735.2258
Massachusetts	Community Research Initiative of New England/HDAP The Schrafft's City Center 529 Main Street, Suite 301 Boston, MA 02129	Toll-free: 1.888.253.2712 Local: 1.617.502.1700
Michigan	Michigan Drug Assistance Program Michigan Department of Health and Human Services Division of Health, Wellness and Disease Control HIV Care Section 109 Michigan Avenue, 9th Floor Lansing, MI 48913	Toll-free: 1.888.826.6565
Minnesota	HIV/AIDS Programs Department of Human Services P.O. Box 64972 St. Paul, MN 55164-0972	Toll-free: 1.800.657.3761 Local: 1.651.431.2414 TTY: 1.800.627.3529
Mississippi	Mississippi Department of Health Office of STD/HIV Care and Services Division P.O. Box 1700 570 East Woodrow Wilson Drive Jackson, MS 39215-1700	Toll-free: 1.888.343.7373 Local: 1.601.362.4879
Missouri	Bureau of HIV, STD, and Hepatitis Missouri Department of Health and Senior Services P.O. Box 570 Jefferson City, MO 65102-0570	Local: 1.573.751.6439 TTY: 711
Montana	Montana Dept. of Public Health and Human Services P.O. Box 202951 Cogswell Bldg C-211 Helena, MT 59620-2951	Local: 1.406.444.4744
Nebraska	Nebraska Department of Health & Human Services Nebraska Ryan White ADAP 301 Centennial Mall South Lincoln, NE 68509	Local: 1.402.471.3121
Nevada	Office of HIV/AIDS Nevada Division of Public and Behavioral Health 4126 Technology Way, Suite 200 Carson City, NV 89706	Local: 1.775.684.4200

AIDS Drug Assistance Programs
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State:	Agency:	Telephone Number:
New Hampshire	New Hampshire Department of Health & Human Services – CARE Program 29 Hazen Drive Concord, NH 03301-6504	Toll-free: 1.800.852.3345 *extension 4502* *(in-state only)* Local: 1.603.271.4502 TTY: 1.800.735.2964
New Jersey	New Jersey Department of Health AIDS Drug Distribution Program (ADDP) P.O. Box 722 Trenton, NJ 08625-0722	Toll-free: 1.877.613.4533
New Mexico	New Mexico Department of Health HIV Services Program 1190 St. Francis Drive, Suite 1200 Santa Fe, NM 87502	Local: 1.505.827.2435
New York	HIV Uninsured Care Programs – ADAP New York State Department of Health Empire Station P.O. Box 2052 Albany, NY 12220-0052	Toll-free: 1.800.542.2437 *(in-state only)* Out-of-state: 1.518.459.1641 TTY: 1.518.459.0121
North Carolina	Communicable Disease Branch Epidemiology Section, Division of Public Health N.C. Dept. of Health and Human Services 1907 Mail Service Center Raleigh, NC 27699-1902	Toll-free: 1.877.466.2232 *(in-state only)* Out-of-state: 1.919.733.9161
North Dakota	North Dakota Department of Health HIV/AIDS Program 2635 East Main Ave. Bismarck, ND 58506-5520	Toll-free: 1.800.472.2180 *(in-state only)* Local: 1.701.328.2378
Northern Mariana Islands	STD/HIV/AIDS Program P.O. Box 500409 Saipan, MP 96950	Local: 1.670.664.4050
Ohio	Ohio Department of Health HIV Care Services Section 246 North High Street Columbus, OH 43215	Toll-free: 1.800.777.4775
Oklahoma	HIV/STD Service Oklahoma State Department of Health 1000 NE 10th Oklahoma City, OK 73117-1299	Local: 1.405.271.4636
Oregon	CAREAssist Program P.O. Box 14450 Portland, OR 97293-0450	Toll-free: 1.800.805.2313 Local: 1.971.673.0144 TTY: 1.971.673.1222
Pennsylvania	Department of Health Special Pharmaceutical Benefits Program P.O. Box 8808 Harrisburg, PA 17105-8808	Local: 1.800.922.9384

AIDS Drug Assistance Programs
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State:	Agency:	Telephone Number:
Puerto Rico	Commonwealth of Puerto Rico Department of Health Ryan White Part B AIDS Drug Assistance Program P.O. Box 70184 San Juan, PR 00936	Local: 1.787.765.2929
Rhode Island	Executive Office of Health and Human Services Office of HIV/AIDS Hazard Building, Suite 60 74 West Road Cranston, RI 02920	Local: 1.401.462.3294
South Carolina	South Carolina AIDS Drug Assistance Program South Carolina Department of Health and Environmental Control 2600 Bull Street Columbia, SC 29201	Toll-free: 1.800.856.9954
South Dakota	South Dakota Department of Health Ryan White Part B CARE Program 615 East 4th Street Pierre, SD 57501-1700	Toll-free: 1.800.592.1861 Local: 1.605.773.3737
Tennessee	Tennessee HIV Drug Assistance Program (HDAP) Tennessee Department of Health 710 James Robertson Parkway Nashville, TN 37243	Local: 1.615.741.7500
Texas	Texas Department of State Health Services HIV Medication Program ATTN: MSJA 1100 West 49th Street Austin, TX 78756-3199	Toll-free: 1.800.255.1090 Local: 1.512.533.3000
U.S. Virgin Islands	United States Virgin Islands Department of Health Communicable Diseases Division 1303 Hospital Ground Charlotte Amalie St. Thomas, VI 00802	Local: 1.340.774.9000
Utah	Utah Department of Health Bureau of Epidemiology 288 North 1460 West, P.O. Box 142104 Salt Lake City, UT 84114-2104	Local: 1.801.538.6197
Vermont	Vermont Medication Assistance Program Vermont Department of Health P.O. Box 70, Drawer 41 IDEPI Burlington, VT 05402	Toll-free: 1.800.244.7639 Local: 1.802.951.4005 TTY: 711
Virginia	Virginia Department of Health HCS Unit, 1st Floor 109 Governor Street Richmond, VA 23219	Toll-free: 1.855.362.0658

AIDS Drug Assistance Programs TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
State:	**Agency:**	**Telephone Number:**
West Virginia	WV Ryan White Part B State Direct Services P.O. Box 6360 Wheeling, WV 26003	Local: 1.304.232.6822
Washington	Early Intervention Program P.O. Box 47841 Olympia, WA 98501	Toll-free: 1.877.376.9316 TTY: 711
Wisconsin	Department of Health Services Division of Public Health P.O. Box 2659 Madison, WI 53701-2659	Toll-free: 1.800.991.5532 Local: 1.608.267.6875 TTY: 711
Wyoming	Wyoming Department of Health Communicable Disease Unit 6101 Yellowstone Road Cheyenne, WY 82002	Local: 1.307.777.5856

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
State:	**Agency:**	**Telephone Number:**
Alabama	State Health Insurance Assistance Program (SHIP) Alabama Department of Senior Services 201 Monroe Street, Suite 350 Montgomery, AL 36104	Toll-free: 1.800.243.5463 Local: 1.334.242.5743
Alaska	State Health Insurance Assistance Program (SHIP) Alaska Medicare Information Office 400 Gambell Street, Suite 303 Anchorage, AK 99501	Toll-free: 1.800.478.6065 *(in-state only)* Local: 1.907.269.3680 TTY: 1.800.770.8973
Arizona	State Health Insurance Assistance Program (SHIP) Arizona Department of Economic Security DES Division of Aging and Adult Services 1789 West Jefferson Street, Site Code 950A Phoenix, AZ 85007	Toll-free: 1.800.432.4040 Local: 1.602.542.4446 TTY: 711
Arkansas	Senior Health Insurance Information Program Arkansas Insurance Department 1200 West Third Street Little Rock, AR 72201-1904	Toll-free: 1.800.224.6330 Local: 1.501.371.2782
California	State Health Insurance Assistance Program (SHIP) California Health Insurance Counseling and Advocacy Program (HICAP) 1300 National Drive, Suite 200 Sacramento, CA 95834-1992	Toll-free: 1.800.434.0222 TTY: 1.800.735.2929
Colorado	Senior Health Insurance Assistance Program (SHIP) Division of Insurance Colorado Department of Regulatory Agencies 1560 Broadway, Suite 850 Denver, CO 80202	Toll-free: 1.888.696.7213 TTY: 1.303.894.7880

State Health Insurance Assistance Programs (SHIPs)
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State:	Agency:	Telephone Number:
Connecticut	CHOICES – Department of Aging 55 Farmington Ave, 12th Floor Hartford, CT 06105-3730	Toll-free: 1.800.994.9422 *(in-state only)* Local: 1.860.424.5274 TTY: 711
Delaware	Delaware Medicare Assistance Bureau (DMAB) Delaware Department of Insurance 841 Silver Lake Boulevard Dover, DE 19904-2465	Toll-free: 1.800.336.9500 Local: 1.302.674.7364
District of Columbia	Health Insurance Counseling Project (HICP) Jacob Burns Community Legal Clinics The George Washington University Law School 650 20th Street, NW Washington, D.C. 20052	Local: 1.202.994.6272 Local: 1.202.739.0668
Florida	SHINE Program Florida Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000	Toll-free: 1.800.963.5337 Local: 1.850.414.2000 TTY: 1.800.955.8770
Georgia	GeorgiaCares Georgia DHS Division of Aging Services 2 Peachtree Street, NW, 33rd Floor Atlanta, GA 30303-3142	Toll-free: 1.866.552.4464 *option #4* Local: 1.404.657.5258 TTY: 711
Guam	Division of Senior Citizens Guam 130 University Drive, Suite 8 University Castle Mall Mangilao, GU 96913	Local: 1.671.735.7421 TTY: 1.671.735.7415
Hawaii	Hawaii SHIP Executive Office on Aging – No. 1 Capitol District 250 South Hotel Street, Suite 406 Honolulu, HI 96813-2831	Toll-free: 1.888.875.9229 Local: 1.808.586.7299 TTY: 1.866.810.4379
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) of Idaho – Department of Insurance 700 West State Street, 3rd Floor P.O. Box 83720 Boise, ID 83720-0043	Toll-free: 1.800.247.4422
Illinois	Senior Health Insurance Program (SHIP) Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271	Toll-free: 1.800.252.8966 TTY: 1.888.206.1327
Indiana	State Health Insurance Assistance Program (SHIP) Indiana Department of Insurance 714 West 53rd Street Anderson, IN 46013	Toll-free: 1.800.452.4800 TTY: 1.866.846.0139
Iowa	Senior Health Insurance Information Program (SHIIP) 601 Locust St., 4th Floor Des Moines, IA 50309-3738	Toll-free: 1.800.351.4664 TTY: 1.800.735.2942 *(in-state only)*

State Health Insurance Assistance Programs (SHIPs)
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State:	Agency:	Telephone Number:
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) Kansas Department for Aging and Disability Services New England Building 503 South Kansas Avenue Topeka, KS 66603-3404	Toll-free: 1.800.860.5260 Toll-free: 1.800.432.3535 *(in-state only)* TTY: 1.800.766.3777
Kentucky	State Health Insurance Assistance Program (SHIP) Kentucky Cabinet for Health and Family Services Department for Aging and Independent Living Office of the Secretary 275 East Main Street, 3E-E Frankfort, KY 40621	Toll-free: 1.877.293.7447 *option #2* Local: 1.502.564.6930 TTY: 1.888.642.1137
Louisiana	Senior Health Insurance Information Program (SHIIP) Louisiana Department of Insurance P.O. Box 94214 Baton Rouge, LA 70804	Toll-free: 1.800.259.5300 Local: 1.225.342.5301
Maine	Office of Aging and Disability Services Maine Department of Health and Human Services 41 Anthony Avenue, SHS 11 Augusta, ME 04333	Toll-free: 1.800.262.2232 Local: 1.207.287.9200 TTY: 711
Maryland	Senior Health Insurance Assistance Program (SHIP) Maryland Department of Aging 301 West Preston Street, Suite 1007 Baltimore, MD 21201	Toll-free: 1.800.243.3425 *(in-state only)* Local: 1.410.767.1100 Out-of-state: 1.844.627.5465
Massachusetts	Serving Health Information Needs of Elders (SHINE) Executive Office of Elder Affairs One Ashburton Place, Room 517 Boston, MA 02108-1618	Toll-free: 1.800.243.4636 Local: 1.617.727.7750 TTY: 1.800.872.0166
Michigan	Michigan Medicare/Medicaid Assistance Program (MMAP, Inc.) 6105 West St. Joseph Highway, Suite 204 Lansing, MI 48917	Toll-free: 1.800.803.7174 Local: 1.517.886.0899
Minnesota	Minnesota SHIP/Senior LinkAge Line Minnesota Board on Aging P.O. Box 64976 St. Paul, MN 55164-0976	Toll-free: 1.800.333.2433 TTY: 1.800.627.3529
Mississippi	State Health Insurance Assistance Program (SHIP) Mississippi Department of Human Services Division of Aging & Adult Services 750 North State Street Jackson, MS 39202	Toll-free: 1.800.948.3090 Local: 1.601.359.4929
Missouri	Missouri CLAIM 200 North Keene Street, Suite 101 Columbia, MO 65201	Toll-free: 1.800.390.3330 Local: 1.573.817.8320

State Health Insurance Assistance Programs (SHIPs)
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State:	Agency:	Telephone Number:
Montana	Montana State Health Insurance Assistance Program (SHIP) Senior and Long Term Care Division 2030 11th Avenue Helena, MT 59601	Toll-free: 1.800.551.3191 Local: 1.406.444.4077 TTY: 1.800.253.4091
Nebraska	Nebraska Senior Health Insurance Information Program (SHIIP) Nebraska Department of Insurance 941 O Street, Suite 400 Lincoln, NE 68508	Toll-free: 1.800.234.7119 Local: 1.402.471.2841 TTY: 1.800.833.7352
Nevada	State Health Insurance Assistance Program (SHIP) 3416 Goni Road, Suite D-132 Carson City, NV 89706	Toll-free: 1.800.307.4444 Local: 1.702.486.3478
New Hampshire	ServiceLink Aging and Disability Resource Center New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301-3857	Toll-free: 1.866.634.9412 TTY: 1.800.735.2964
New Jersey	State Health Insurance Assistance Program (SHIP) New Jersey Department of Human Services Division of Aging Services P.O. Box 715 Trenton, NJ 08625-0715	Toll-free: 1.800.792.8820 *(in-state only)* Toll-free: 1.877.222.3737
New Mexico	Benefits Counseling Program New Mexico Aging and Long-Term Services Department P.O. Box 27118 Santa Fe, NM 87502-7118	Local: 1.505.476.4799 TTY: 1.505.476.4937
New York	Health Insurance Information Counseling and Assistance Program (HIICAP) New York State Office for the Aging 2 Empire State Plaza Agency Building # 2, 4th Floor Albany, NY 12223-1251	Toll-free: 1.800.701.0501 Toll-free: 1.800.342.9871
North Carolina	Seniors' Health Insurance Information Program (SHIIP) North Carolina Department of Insurance 1201 Mail Service Center Raleigh, NC 27699-1201	Toll-free: 1.855.408.1212 Local: 1.919.807.6900 TTY: 1.800.735.2962
North Dakota	State Health Insurance Counseling Program (SHIC) North Dakota Insurance Department 600 East Boulevard Avenue Bismarck, ND 58505-0320	Toll-free: 1.888.575.6611 Local: 1.701.328.2440 TTY: 1.800.366.6888

State Health Insurance Assistance Programs (SHIPs)
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State:	Agency:	Telephone Number:
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP) Ohio Department of Insurance 50 West Town Street, 3rd Floor, Suite 300 Columbus, OH 43215	Toll-free: 1.800.686.1578 Local: 1.614.644.2658 TTY: 1.614.644.3745
Oklahoma	Senior Health Insurance Counseling Program (SHIP) Oklahoma Insurance Department 5 Corporate Plaza 3625 NW 56th Street, Suite 100 Oklahoma City, OK 73112	Toll-free: 1.800.763.2828 *(in-state only)* Local: 1.405.521.6628
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter Street NE Salem, OR 97309-0405	Toll-free: 1.800.722.4134 Local: 1.503.947.7979 TTY: 1.800.735.2900
Pennsylvania	APPRISE Commonwealth of Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919	Toll-free: 1.800.783.7067
Puerto Rico	State Health Insurance Assistance Program (SHIP) P.O. Box 50063 San Juan, PR 00902	Toll-free: 1.800.981.7735 *(San Juan)* Local: 1.787.721.6121
Rhode Island	Senior Health Insurance Program (SHIP) Rhode Island Department of Human Services Division of Elderly Affairs 57 Howard Avenue Louis Pasteur Bldg., 2nd Floor Cranston, RI 02920	Local: 1.401.462.3000 TTY: 1.401.462.0740
South Carolina	Insurance Counseling Assistance and Referrals for Elders (I-CARE) Lieutenant Governor's Office on Aging 1301 Gervais Street, Suite 350 Columbia, SC 29201	Toll-free: 1.800.868.9095 Local: 1.803.734.9900
South Dakota	Senior Health Information and Insurance Education (SHIINE) South Dakota Department of Social Services 700 Governors Drive Pierre, SD 57501	Toll-free: 1.800.536.8197 Local: 1.605.333.3314
Tennessee	Tennessee State Health Insurance Information Program (SHIP) Tennessee Commission on Aging and Disability Andrew Jackson Building 502 Deaderick Street, 9th Floor Nashville, TN 37243-0860	Toll-free: 1.877.801.0044 Local: 1.615.741.2056 TTY: 1.800.848.0299

State Health Insurance Assistance Programs (SHIPs)
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State:	Agency:	Telephone Number:
Texas	Health Information Counseling and Advocacy Program (HICAP) – Texas Department of Aging and Disability Services (DADS) P.O. Box 149030 Austin, TX 78714-9030	Toll-free: 1.800.252.9240 Local: 1.512.438.3011 TTY: 1.800.735.2989
U.S. Virgin Islands	VI SHIP Office Schneider Regional Medical Center 9048 Sugar Estate, 1st Floor St. Thomas, VI 00802 VI SHIP Office Gov. Juan F. Luis Hospital and Medical Center 4007 Estate Diamond, 1st Floor St. Croix, VI 00820	Local: 1.340.714.4354 *(St. Thomas)* Local: 1.340.772.7368 *(St. Croix)*
Utah	Senior Health Insurance Information Program (SHIIP) Aging and Adult Services of Utah 195 North 1950 West Salt Lake City, UT 84116	Toll-free: 1.877.424.4640 or 1.800.541.7735 Local: 1.801.538.3910
Vermont	State Health Insurance Assistance Program (SHIP) 76 Pearl Street, Suite 201 Essex Junction, VT 05452	Toll-free: 1.800.642.5119 *(in-state only)* Local: 1.802.865.0360
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP) Virginia Division for the Aging 1610 Forest Avenue, Suite 100 Henrico, VA 23229	Toll-free: 1.800.552.3402 Local: 1.804.662.9333 TTY: 711
Washington	Statewide Health Insurance Benefits Advisors (SHIBA) Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255	Toll-free: 1.800.562.6900 TTY: 1.360.586.0241
West Virginia	West Virginia State Health Insurance Assistance Program (WV SHIP) West Virginia Bureau of Senior Services 1900 Kanawha Boulevard East Charleston, WV 25305	Toll-free: 1.877.987.4463 Local: 1.304.558.3317
Wisconsin	State Health Insurance Assistance Program (SHIP) Department of Health Services Board on Aging and Long Term Care 1 West Wilson Street Madison, WI 53703	Toll-free: 1.800.242.1060 Local: 1.608.266.1865 TTY: 1.888.701.1251
Wyoming	Wyoming State Health Insurance Information Program (WSHIIP) 106 West Adams Avenue Riverton, WY 82501	Toll-free: 1.800.856.4398 Local: 1.307.856.6880

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
State:	**Agency:**	**Telephone Number:**
Alabama	Alabama Medicaid Agency P.O. Box 5624 Montgomery, AL 36103-5624	Toll-free: 1.800.362.1504 Local: 1.334.242.5000
Alaska	Alaska Department of Health and Social Services 350 Main Street, Room 404 P.O. Box 110601 Juneau, AK 99811-0601	Toll-free: 1.800.770.5650 Local: 1.907.465.3347 TTY: 1.907.586.4265
American Samoa	American Samoa Medicaid State Agency ASTCA Executive Building #304 P.O. Box 998383 Pago Pago, AS 96799	Local: 1.684.699.4777
Arizona	Arizona Health Care Cost Containment System (AHCCCS) 801 East Jefferson Street, MD 4100 Phoenix, AZ 85034	Toll-free: 1.800.654.8713 *(in state only)* Toll-free: 1.800.523.0231 Local: 1.602.417.4000 TTY: 1.602.417.4191
Arkansas	Arkansas Division of Medical Services Department of Human Services Donaghey Plaza South P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437	Toll-free: 1.800.482.8988 Local: 1.501.682.8233
California	Medi-Cal Department of Health Care Services P.O. Box 997417, MS 4607 Sacramento, CA 95899-7417	Local: 1.916.552.9200
Colorado	Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818	Local: 1.800.221.3943 TTY: 711
Connecticut	Husky Health Program c/o Department of Social Services 55 Farmington Avenue Hartford, CT 06105	Toll-free: 1.877.284.8759 TTY: 1.866.492.5276
Delaware	Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 North DuPont Highway, Lewis Building New Castle, DE 19720	Toll-free: 1.800.372.2022 Local: 1.302.255.9500
District of Columbia	DC Department of Health Care Finance 441 4th Street, NW, 900S Washington, DC 20001	Local: 1.202.727.5355 TTY: 711
Florida	Florida Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL 32308	Toll-free: 1.888.419.3456 TTY: 1.800.955.8771
Georgia	Georgia Department of Community Health 2 Peachtree Street Northwest Atlanta, GA 30303	Toll-free: 1.866.211.0950 Local: 1.404.656.4507

State Medicaid Offices
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State:	Agency:	Telephone Number:
Guam	Medicaid/NIP Off-Island Referral Office Bureau of Health Care Financing Administration Room 238 123 Chalan Kareta Mangilao, GU 96913	Local: 1.671.735.7224 or 1.671.735.7302
Hawaii	Med-QUEST Division Department of Human Services 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817	Toll-free: 1.800.316.8005 Local: 1.808.524.3370
Idaho	Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720-0026	Local: 1.877.456.1233 TTY: 1.800.377.1363
Illinois	Illinois Department of Healthcare and Family Services 201 South Grand Avenue East Springfield, IL 62763	Toll-free: 1.800.226.0768 Local: 1.217.557.4257 TTY: 1.877.204.1012
Indiana	Family and Social Services Administration Office of Medicaid Policy and Planning 402 West Washington Street P.O. Box 7083 Indianapolis, IN 46204	Toll-free: 1.800.889.9949 Toll-free: 1.800.403.0864 Local: 1.317.713.9627
Iowa	Iowa Medicaid Enterprise Department of Human Services – Member Services P.O. Box 36510 Des Moines, IA 50315	Toll-free: 1.800.338.8366 Local: 1.515.256.4606 TTY: 1.800.735.2942
Kansas	KanCare 900 S.W. Jackson, Suite 900N Topeka, KS 66612-1220	Toll-free: 1.866.305.5147 TTY: 1.800.766.3777
Kentucky	Department for Medicaid Services Cabinet for Health and Family Services Office of the Secretary 275 East Main Street Frankfort, KY 40621	Toll-free: 1.800.635.2570 Local: 1.502.564.4321
Louisiana	Department of Health and Hospitals P.O. Box 629 Baton Rouge, LA 70821-0629	Toll-free: 1.888.342.6207
Maine	Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011	Toll-free: 1.800.977.6740 Local: 1.207.287.2674 TTY: 711
Maryland	Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201	Toll-free: 1.877.463.3464 Local: 1.410.767.6500
Massachusetts	MassHealth Office of Medicaid 1 Ashburton Place, 11th Floor Boston, MA 02108	Toll-free: 1.877.841.2900 TTY: 1.800.497.4648

State Medicaid Offices
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State:	Agency:	Telephone Number:
Michigan	Michigan Department of Community Health Capitol View Building 333 S. Grand Avenue Lansing, MI 48909	Local: 1.517.373.3740 TTY: 711
Minnesota	Department of Human Services Health Care Eligibility and Access Division P.O. Box 64989 St. Paul, MN 55164-0989	Toll-free: 1.800.657.3739 Local: 1.651.431.2670 TTY: 1.800.627.3529
Mississippi	Mississippi Division of Medicaid Sillers Building 550 High Street, Suite 1000 Jackson, MS 39201-1399	Toll-free: 1.800.421.2408 Local: 1.601.359.6050
Missouri	The State of Missouri MO HealthNet Division 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500	Toll-free: 1.800.392.2161 Local: 1.573.751.3425 TTY: 1.800.735.2966
Montana	Department of Public Health and Human Services Health Resources Division 1400 East Broadway Street, Cogswell Building Helena, MT 59601-5231	Toll-free: 1.800.362.8312 Local: 1.406.444.4540
Nebraska	Department of Health and Human Services Access Nebraska P.O. Box 95026 Lincoln, NE 68509-5026	Toll-free: 1.855.632.7633 Local: 1.402.471.3121 TTY: 1.402.471.7256
Nevada	Department of Health and Human Services Division of Health Care Financing and Policy 1100 East William Street, Suite 101 Carson City, NV 89701	Toll-free: 1.877.638.3472 Local: 1.775.684.3600
New Hampshire	Department of Health and Human Services Office of Medicaid Business and Policy 129 Pleasant Street Concord, NH 03301	Toll-free: 1.800.852.3345 *extension 4344 (in-state only)* Local: 1.603.271.4344 TTY: 1.800.735.2964
New Jersey	Department of Human Services Division of Medical Assistance and Health Services P.O. Box 712 Trenton, NJ 08625-0712	Toll-free: 1.800.356.1561 *(in-state only)* TTY: 1.877.294.4356
New Mexico	Human Services Department Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504-2348	Toll-free: 1.888.997.2583

State Medicaid Offices
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.

State:	Agency:	Telephone Number:
New York	New York State Department of Health Corning Tower Empire State Plaza Albany, NY 12237	Toll-free: 1.800.541.2831
North Carolina	Department of Health and Human Services Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	Toll-free: 1.800.662.7030 Local: 1.919.855.4100
North Dakota	Department of Human Services Medical Services Division 600 East Boulevard Avenue, Department 325 Bismarck, ND 58505-0250	Toll-free: 1.800.755.2604 Local: 1.701.328.7068 TTY: 1.800.366.6888
Northern Mariana Islands	State Medicaid Agency Government Bldg. No. 1252 Capitol Hill Rd. Caller Box 10007 Saipan, MP 96950	Local: 1.670.664.4890
Ohio	Department of Medicaid 50 West Town Street, Suite 400 Columbus, OH 43215	Toll-free: 1.800.324.8680
Oklahoma	Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105	Toll-free: 1.800.987.7767 Local: 1.405.522.7300 TTY: 1.800.757.5979
Oregon	Oregon Health Plan Health Systems Division 500 Summer Street, NE Salem, OR 97301-1079	Toll-free: 1.800.527.5772 Local: 1.503.945.5772 TTY: 711
Pennsylvania	Department of Human Services Office of Medical Assistance Programs P.O. Box 2675 Harrisburg, PA 17105-2675	Toll-free: 1.800.842.2020 TTY: 1.800.451.5886
Puerto Rico	Puerto Rico Medicaid Calle Eleanor Roosevelt #117 Hato Rey, PR	Local: 1.787.765.1230 TTY: 1.602.417.4191
Rhode Island	Department of Human Services Louis Pasteur Building 600 New London Avenue Cranston, RI 02920	Local: 1.401.462.5300 TTY: 1.800.745.5555
South Carolina	Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206	Toll-free: 1.888.549.0820 TTY: 1.888.842.3620
South Dakota	Department of Social Services 700 Governors Drive Pierre, SD 57501	Toll-free: 1.800.597.1603 Local: 1.605.773.4678 Local: 1.605.773.3165

State Medicaid Offices
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State:	Agency:	Telephone Number:
Tennessee	TennCare 310 Great Circle Road Nashville, TN 37243	Toll-free: 1.855.259.0701 Toll-free: 1.800.342.3145 TTY: 1.877.779.3103
Texas	Texas Health and Human Services Commission Brown-Heatly Building 4900 North Lamar Boulevard, 4th Floor Austin, TX 78751-2316	Local: 1.512.424.6500 TTY: 1.512.424.6597
U.S. Virgin Islands	VI Medicaid Program Department of Human Services Knud Hansen Complex 1303 Hospital Ground, Bldg. A St. Thomas, VI 00802 VI Medicaid Program Department of Human Services 3011 Golden Rock, Christiansted St. Croix, VI 00820	Local: 1.340.715.6929
Utah	Utah Department of Health Division of Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106	Toll-free: 1.800.662.9651 Local: 1.801.538.6155
Vermont	Department of Vermont Health Access Agency of Human Services 280 State Drive Waterbury, VT 05671-1010	Toll-free: 1.800.250.8427 TTY: 1.888.834.7898
Virginia	Department of Medical Assistance Services 600 East Broad Street Richmond, VA 23219	Toll-free: 1.855.242.8282 Local: 1.804.786.7933 TTY: 1.800.343.0634
Washington	Department of Social and Health Services Customer Service Center P.O. Box 11699 Tacoma, WA 98411-9905	Toll-free: 1.800.562.3022 TTY: 711
West Virginia	Department of Health and Human Resources Bureau for Medical Services 350 Capitol Street, Room 251 Charleston, WV 25301	Toll-free: 1.888.483.0793 Local: 1.304.558.1700
Wisconsin	Department of Health Services 1 West Wilson Street Madison, WI 53703	Local: 1.608.266.1865 TTY: 711
Wyoming	Division of Healthcare Financing, Medicaid 6101 Yellowstone Road, Suite 210 Cheyenne, WY 82002	Toll-free: 1.855.294.2127 Local: 1.307.777.7531 TTY: 1.855.329.5204

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
State:	**Agency:**	**Telephone Number:**
Colorado	Bridging the Gap Colorado AIDS Drug Assistance Program (ADAP) Colorado Department of Public Health and Environment DCEED-STD-A3-3800 4300 Cherry Creek Drive South Denver, CO 80246-1530	Local: 1.303.692.2716
Delaware	Chronic Renal Disease Program (CRDP) Division of Medicaid and Medical Assistance at Riverwalk 253 Northeast Front Street Milford, DE 19963	Local: 1.302.424.7180
Idaho	Idaho AIDS Drug Assistance Program (IDAGAP) Department of Health and Welfare Idaho Ryan White Part B Program 450 West State Street, 4th Floor P.O. Box 83720 Boise, ID 83720-0036	Toll-free: 1.800.926.2588 Local: 1.208.334.6657 Alternate main line: 1.208.334.6527
Indiana	HoosierRx P.O. Box 6224 Indianapolis, IN 46206-6224	Toll-free: 1.866.267.4679 Local: 1.317.234.1381
Maine	Low Cost Drugs for the Elderly and Disabled Program (DEL), Office of Aging & Disability Services Maine Department of Health and Human Services 11 State House Station 41 Anthony Avenue Augusta, ME 04333	Toll-free: 1.800.262.2232 Local: 1.207.287.9200 TTY: 711
Maryland	Maryland Senior Prescription Drug Assistance Program (SPDAP) c/o Pool Administrators 628 Hebron Avenue, Suite 100 Glastonbury, CT 06033	Toll-free: 1.800.551.5995 TTY: 1.800.877.5156
Maryland	Maryland Kidney Disease Program 201 West Preston Street, Room SS-3 Baltimore, MD 21201	Local: 1.410.767.5000
Massachusetts	Prescription Advantage P.O. Box 15153 Worcester, MA 01615-0153	Toll-free: 1.800.243.4636 (1.800.AGE.INFO) *extension 2* TTY: 1.877.610.0241

State Pharmaceutical Assistance Programs (SPAPs)
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.

State:	Agency:	Telephone Number:
Missouri	Missouri Rx Plan P.O. Box 6500 Jefferson City, MO 65102-6500	Toll-free: 1.800.375.1406
Montana	Big Sky Rx Program P.O. Box 202915 Helena, MT 59620-2915	Toll-free: 1.866.369.1233 Out-of-state: 1.406.444.1233 & Helena
Montana	Mental Health Services Plan (MHSP) Addictive and Mental Disorders Division 100 North Park Avenue, Suite 300, P.O. Box 202905 Helena, MT 59620-2905	Toll-free: 1.888.866.0328 Local: 1.406.444.3964
Montana	Department of Public Health and Human Services HIV/STD/Hep C Prevention Bureau Cogswell Building 1400 Broadway Room C-211 Helena, MT 59601	Local: 1.406.444.3565
Nevada	Nevada Senior Rx Department of Health and Human Services Aging and Disability Services Division 3416 Goni Road, Building D, Suite D-132 Carson City, NV 89706	Toll-free: 1.866.303.6323 Local: 1.775.687.4210 *(Reno, Carson City, Gardnerville)*
New Jersey	New Jersey Department of Human Services Pharmaceutical Assistance to the Aged and Disabled (PAAD), Lifeline and Special Benefit Programs Senior Gold Prescription Discount Program (Senior Gold) P.O. Box 715 Trenton, NJ 08625-0715	Toll-free: 1.800.792.9745
New York	Elderly Pharmaceutical Insurance Coverage (EPIC) P.O. Box 15018 Albany, NY 12212-5018	Toll-free: 1.800.332.3742 TTY: 1.800.290.9138
North Carolina	North Carolina HIV SPAP 1902 Mail Service Center Raleigh, NC 27699-1902	Toll-free: 1.877.466.2232 *(in-state only)* Local: 1.919.733.9161
Pennsylvania	The Chronic Renal Disease Program Pennsylvania Department of Health Division of Child and Adult Health Services 625 Forster Street, 7th Floor, East Wing Harrisburg, PA 17120-0701	Toll-free: 1.877.724.3258 or 1.800.225.7223
Pennsylvania	PACE/PACENET Program Bureau of Pharmaceutical Assistance P.O. Box 8806 Harrisburg, PA 17105-8806	Toll-free: 1.800.225.7223 Local: 1.717.787.7313

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
State:	**Agency:**	**Telephone Number:**
Pennsylvania	Special Pharmaceutical Benefits Program – HIV/AIDS P.O. Box 8808 Harrisburg, PA 17105-8808	Local: 1.800.922.9384
Rhode Island	Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) Attention: RIPAE, Rhode Island Department of Human Services – Division of Elderly Affairs 57 Howard Avenue, Louis Pasteur Building, 2nd Floor Cranston, RI 02920	Local: 1.401.462.3000 TTY: 1.401.462.0740
Texas	Kidney Health Care Program (KHC) Specialty Health Care Services, MC 1938 P.O. Box 149347 Austin, TX 78714-9347	Toll-free: 1.800.222.3986 Local: 1.512.776.7150
Texas	Texas HIV State Pharmaceutical Assistance Program (SPAP) – Department of State Health Services HIV/STD Program P.O. Box 149347, MC 1873 Austin, TX 78714	Toll-free: 1.800.255.1090 *option #4*
U.S. Virgin Islands	Department of Human Services Knud Hansen Complex 1303 Hospital Ground, Bldg. A St. Thomas, VI 00802 Department of Human Services 3011 Golden Rock, Christiansted St. Croix, VI 00820	Local: 1.340.774.0930 *(St. Thomas)* 1.340.773.2323 *(St. Croix)* 1.340.776.6334 *(St. John)*
Vermont	VPharm/Healthy Vermonters 312 Hurricane Lane, Suite 201 Williston, VT 05495	Toll-free: 1.800.250.8427 TTY: 1.888.834.7898
Virginia	Virginia AIDS Drug Assistance Program (ADAP) and Virginia HIV SPAP, Patient Services Incorporated P.O. Box 5930 Midlothian, VA 23112	Toll-free: 1.800.366.7741
Washington	Washington State Health Insurance Pool (WSHIP) P.O. Box 1090 Great Bend, KS 67530	Toll-free: 1.800.877.5187
Wisconsin	Wisconsin Chronic Disease Program (Chronic Renal Disease, Cystic Fibrosis, and Hemophilia Home Care Programs) P.O. Box 6410, Attn: Eligibility Unit Madison, WI 53716-0410	Toll-free: 1.800.362.3002
Wisconsin	Wisconsin SeniorCare P.O. Box 6710 Madison, WI 53716-0710	Toll-free: 1.800.657.2038

Quality Improvement Organizations TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.		
Area:	**Agency:**	**Telephone Number:**
Area 1	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	Toll-free: 1.866.815.5440 TTY: 1.866.868.2289 Fax: 1.844.420.6671
Area 1 includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands		
Area 2	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	Toll-free: 1.844.455.8708 TTY: 1.855.843.4776 Fax: 1.844.834.7129
Area 2 includes District of Columbia, Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia		
Area 3	KEPRO 5700 Lombardo Center Drive Suite 100 Seven Hills, OH 44131	Toll-free: 1.844.430.9504 TTY: 1.855.843.4776 Fax: 1.844.878.7921
Area 3 includes Alabama, Arkansas, Colorado, Kentucky, Louisiana, Mississippi, Montana, North Dakota, New Mexico, Oklahoma, South Dakota, Tennessee, Texas, Utah, Wyoming		
Area 4	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	Toll-free: 1.855.408.8557 TTY: 1.855.843.4776 Fax: 1.844.834.7130
Area 4 includes Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin		
Area 5	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	Toll-free: 1.877.588.1123 TTY: 1.855.887.6668 Fax: 1.855.694.2929
Area 5 includes Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Northern Mariana Islands, Nevada, Oregon, Washington		

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