



Anthem Blue Cross MedicareRx (PDP) EVIDENCE OF COVERAGE

HIGH Plan

Anthem Blue Cross Life and Health Insurance Company (Anthem) has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Medicare Prescription Drug Plans (PDPs) noted above or herein Anthem is the state-licensed, risk-bearing entity offering these plans. Anthem has retained the services of its related companies and authorized agents/brokers/producers to provide administrative services and/or to make the PDPs available in this region. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. IA_C0003_10GRP_022 09/15/2009



This booklet is your Anthem Blue Cross MedicareRx (PDP) Prescription Drug Evidence of Coverage (EOC). For questions regarding your coverage please call customer service, 7 days a week, from 8a.m. to 8p.m. at 1-866-470-6265. TTY/TDD users can call 1-877-247-1657.



EVIDENCE OF COVERAGE

January 1, 2010 – December 31, 2010

Your Medicare Prescription Drug Coverage as a Member of Anthem Blue Cross MedicareRx (PDP)

This booklet gives you the details about your Medicare prescription drug coverage from **January 1, 2010 – December 31, 2010**. It explains how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Customer Service:

For help or information, please call Customer Service or go to our plan website.

1-866-470-6265 (Calls to these numbers are free.)

TTY/TDD users call: 1-877-247-1657

Website: www.anthem.com/ca

Hours of Operation:

8 a.m. to 8 p.m.

7 days a week

This plan is offered by Anthem Blue Cross, referred to throughout the Evidence of Coverage as “we,” “us,” or “our.” Anthem Blue Cross MedicareRx is referred to as “plan” or “your plan.”

A Medicare-approved Part D sponsor.

This information may be available in a different format, including other languages and large print. Please call Customer Service at the number listed above if you need plan information in another format or language.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

Your 2010 Prescription Drug Benefit Chart
Premier 10/25/40
University of California – High Option Supplement Plan
Effective 01/01/2010

| Formulary | Premier 3 Tier - Open |
|---|---|
| Covered Services | What you pay |
| Initial Coverage | |
| Below is your payment responsibility until the cost paid by you for your prescriptions reaches your True Out of Pocket cost of \$1,000. | |
| Retail Pharmacy | per 30-day supply |
| <ul style="list-style-type: none"> • Generics, including Specialty Drugs | \$10 copay (Specialty is not limited to a 30-day supply) |
| <ul style="list-style-type: none"> • Select Generics | \$0 copay for Select Generics |
| <ul style="list-style-type: none"> • Preferred Brands, including Specialty Drugs and Vaccines | \$25 copay (Specialty is not limited to a 30-day supply) |
| <ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs¹ | \$40 copay |
| <ul style="list-style-type: none"> • Contraceptive Devices, limited to 1 per year • Diabetic Supplies • Diabetic Syringes | \$0 copay \$0 copay \$25 copay |
| Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays. | |
| Mail Order Pharmacy | per 90-day supply |
| <ul style="list-style-type: none"> • Generics, including Specialty Drugs | \$20 copay (Specialty is not limited to a 30-day supply) |
| <ul style="list-style-type: none"> • Select Generics | \$0 copay for Select Generics |
| <ul style="list-style-type: none"> • Preferred Brands, including Specialty Drugs and Vaccines | \$50 copay (Specialty is not limited to a 30-day supply) |
| <ul style="list-style-type: none"> • Non-Preferred Brands and Non Formulary Drugs¹ | \$80 copay |
| <ul style="list-style-type: none"> • Contraceptive Devices, limited to 1 per year • Diabetic Supplies • Diabetic Syringes | \$0 copay \$0 copay \$50 copay |

If you purchase drugs at Retail or Mail Order Pharmacies that are not listed in our participating pharmacy directory, you will be responsible for all amounts over our negotiated cost. If you need an emergency supply of drugs and you are not near a Retail Pharmacy in our participating pharmacy directory, you will not be responsible for amounts over our negotiated costs.

Vaccine Coverage

The up front costs for vaccines will vary based upon where the vaccine is purchased and administered. Some vaccines, such as Flu Vaccines, are paid under your Medicare Part B coverage. Vaccines that are covered by Medicare Part B are not covered by your Part D plan. Please see your Evidence of Coverage booklet for a complete explanation of your vaccine coverage.

Covered Services

What you pay

Catastrophic Coverage

Your payment responsibility changes after the cost you have paid for prescription drugs reaches your True Out of Pocket cost of \$1,000.

| | |
|---|--|
| <ul style="list-style-type: none"> • Generics, including Specialty Drugs | <p>\$0 copay (Specialty is not limited to a 30-day supply)</p> |
| <ul style="list-style-type: none"> • Select Generics | <p>\$0 copay for Select Generics</p> |
| <ul style="list-style-type: none"> • Preferred and Non-Preferred Brands, including Specialty Drugs, Vaccines | <p>\$0 copay (Specialty is not limited to a 30-day supply)</p> |
| <ul style="list-style-type: none"> • Non-Formulary Drugs | <p>Retail - \$40 copay Mail Order - \$80 copay</p> |

Extra Covered Drug Groups

These are drugs that are covered by your plan that are often excluded from Part D Prescription Drug Plans. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.

| | |
|---|---|
| <p>Benzodiazepines and Barbiturates Cosmetics Cough and Cold DESI Non Part D Diabetic Supplies (Lancets/test strips) Over the Counter Vitamins and Minerals Analgesics</p> | <p>See Formulary for complete list of drugs covered</p> |
| <ul style="list-style-type: none"> • Generics | <p>You pay your retail or mail order generic copay</p> |
| <ul style="list-style-type: none"> • Preferred and Non-Preferred Brands | <p>You pay your retail or mail order brand copay</p> |

¹ When a member's physician has specified "dispense as written" (DAW) for non-preferred brand name drugs or non-formulary drugs, the copay for preferred brand name formulary drugs will apply.

When a member's physician has not specified DAW for non-preferred brand name drugs or non-formulary drugs, the Tier 3 copay will apply.

Retail Pharmacy Supply Limits (participating and non-participating) – 30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but, require a double copay (available only at retail pharmacies).

UC Medical Center Retail Pharmacies – Member may obtain a 90-day supply of a drug at a UC Medical Center retail pharmacy. Mail Order copays apply.

Outpatient Specialty Medications – Outpatient specialty medications must be dispensed by PrecisionRX Specialty Solutions.
Specialty medications are not limited to a 30-day supply.

Annual Out of Pocket – Member copays for drugs covered under "Extra Covered Drug Groups" or non-formulary drug benefits do not apply towards satisfaction of your annual out of pocket maximum. Additionally, these drugs do not qualify for 100% coverage after you meet your annual out of pocket maximum.

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Section

1. Introduction

1.1

What is the Evidence of Coverage booklet about?

This Evidence of Coverage booklet tells you how to get your Medicare prescription drug coverage through your plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of your plan.

- You are covered by Original Medicare for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through your plan, Anthem Blue Cross MedicareRx.

This plan is offered by Anthem Blue Cross, referred to throughout the Evidence of Coverage as “we,” “us,” or “our.” Anthem Blue Cross MedicareRx is referred to as “plan” or “your plan.”

The words “coverage” and “covered drugs” refer to the prescription drug coverage available to you as a member of Anthem Blue Cross MedicareRx.

1.2

What does this Chapter tell you?

Look through Chapter 1 of this Evidence of Coverage to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- What is your plan’s service area?
- How do you keep the information in your membership record up to date?

1.3

What if you are new to your plan?

If you are a new member, then it’s important for you to learn how your plan operates – what the rules are and what coverage is available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact your plan’s Customer Service (**phone numbers are listed on the front cover of this booklet**).

Section

1.4

Legal information about the Evidence of Coverage**It's part of our contract with you**

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

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

Medicare must approve our plan each year

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

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

2.1

Your eligibility requirements

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

- You are eligible for coverage under your (or your spouse's) former employer's group health plan retiree benefits. If you have questions regarding your eligibility for coverage under your (or your spouse's) former employer's retiree benefits, please contact the employer's benefit administrator.
- You live in the service area in which we can provide retired group members access to network pharmacies which includes all 50 United States and the District of Columbia.
- And, you are entitled to Medicare Part A or you are enrolled in Medicare Part B (or you have both Part A and Part B).

2.2

What are Medicare Part A and Medicare Part B?

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 covers services furnished by providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

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2.3

Here is the service area for your plan

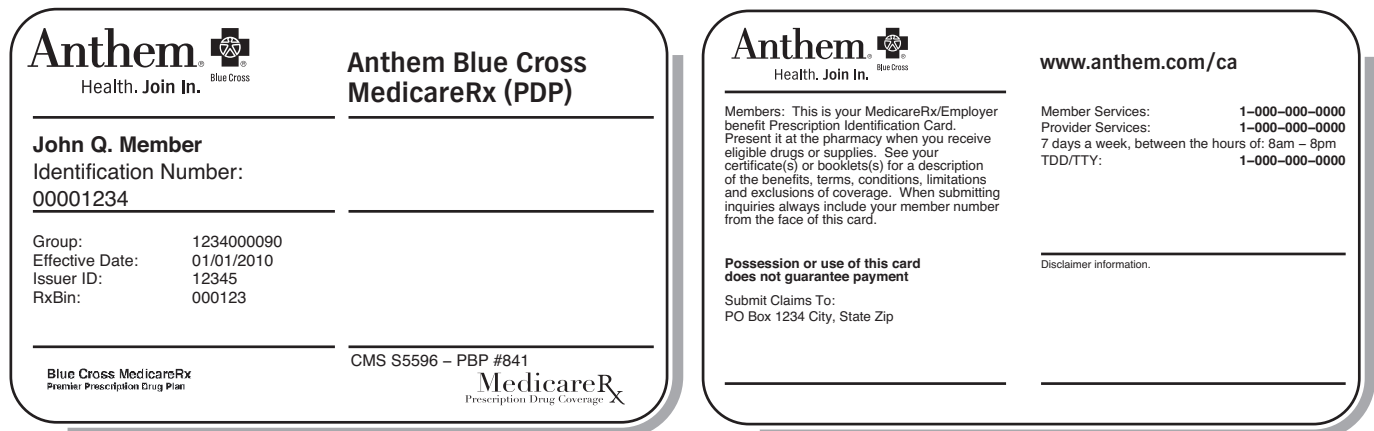
Although Medicare is a federal program, your plan is available only to individuals who live in the service area. To stay a member of your employer/union sponsored plan, you must keep living in one of the 50 United States or the District of Columbia. We can not service retirees or their dependents if they live outside the United States.

If you plan to move out of the service area, please contact Customer Service.

3. What other materials will you get from us?

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

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



Sample Membership Card (Front and Back)

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

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

Section

3.2

The Pharmacy Directory: your guide to pharmacies in our network

What are “network pharmacies”?

Our Pharmacy Directory gives you a complete list of network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for plan members.

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 your plan to cover (help you pay for) them.

We will send you a complete Pharmacy Directory **at least once every three years.**

Every year that you don't get a new Pharmacy Directory, we'll send you a booklet that shows changes to the directory.

If you don't have the Pharmacy Directory, you can get a copy from Customer Service (phone numbers are listed on the front cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network.

3.3

Your plan's List of Covered Drugs (Formulary)

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

We will send you a copy of your drug list. To get the most complete and current information about which drugs are covered, you can call Customer Service (phone numbers are listed on the front cover of this booklet).

3.4

Reports with a summary of payments made for your prescription drugs

When you use your prescription drug benefits, we will send you a report to help you understand and keep track of payments for your prescription drugs. This summary report is called the Explanation of Benefits.

The Explanation of Benefits tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. Chapter 4, (What you pay for your Part D prescription drugs.) gives more

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information about the Explanation of Benefits and how it can help you keep track of your drug coverage.

An Explanation of Benefits summary is also available upon request. To get a copy, please contact Customer Service.

4. Your monthly premium

4.1

How much is your plan premium?

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

In some situations, you might qualify for help paying your plan premium

There are programs to help people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about these programs. If you qualify for one of these programs, enrolling in the program might make your monthly plan premium lower.

If you are already enrolled and getting help from one of these programs, **some of the payment information in this Evidence of Coverage may not apply to you.** You will be mailed the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), that tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Service are listed on the front cover of this booklet. Or, if you are a member of a State Pharmacy Assistance Program (SPAP) and they are helping with your premium costs, please contact your SPAP to determine what help is available to you. For contact information, please refer to the state specific agency listing located in the back of this booklet.

Because you are enrolled in an employer sponsored plan, we will credit the amount of Extra Help received to your prior employer's bill on your behalf. If your employer pays 100% of the premium for your retiree coverage, then they are entitled to keep these funds. However, if you contribute to the premium, your former employer must apply the subsidy toward the amount you contribute to this plan.

In some situations, your plan premium could include a penalty charge each month

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous

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period of 63 days or more when they didn't keep credible drug coverage (as good as Medicare's Part D coverage). For these members, the monthly late enrollment penalty amount is added to the plan's monthly premium. For members on employer sponsored plans this amount is usually added to the premium charged to the employer, unless you are normally billed directly by your plan.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 4, Section 10 explains the late enrollment penalty.

If you think that you may have a late enrollment penalty, you may want to contact your (or your spouse's) former employer's benefit administrator to find out what you will have to pay towards the penalty.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B.

- Your copy of *Medicare & You 2010* tells about these premiums in the section called "2010 Medicare Costs." This explains how the Part B 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 2010* from the Medicare website (<http://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.

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

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

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for Extra Help or if you lose your eligibility

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for Extra Help during the year. If a member qualifies for Extra Help with their prescription drug costs, Extra Help will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about Extra Help in Chapter 2, Section 7.

What if you believe you have qualified for "Extra Help"?

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, your plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

Please fax or mail a copy of your paperwork showing you qualify for subsidy. Below are examples of what paperwork you can provide:

Proof of LIS Status

- A copy of a member's Medicaid card that includes the member's name and the eligibility date during the discrepant period.
- A copy of a letter from the State or SSA showing Medicare Low-Income Subsidy status.
- The date that a verification call was made to the State Medicaid Agency, the name and telephone number of the state staff person who verified the Medicaid period, and the Medicaid eligibility dates confirmed on the call.
- A copy of a state document that confirms active Medicaid status during the discrepant period.
- A screen-print from the State's Medicaid systems showing Medicaid status during the discrepant period.; or
- evidence at point-of-sale of recent Medicaid billing and payment in the pharmacy's patient profile, backed up by one of the above indicators post point-of-sale.
- A print out from the State electronic enrollment file showing Medicaid status during the discrepant period.

Section
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- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period.
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- 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 the discrepant period.

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 (phone numbers are listed on the front cover of this booklet) if you have questions.

5. Please keep your plan membership record up to date**5.1 How to help make sure that we have accurate information about you**

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

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

Call Customer Service to let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other medical or drug insurance coverage you have (such as from your 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.

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under your plan.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are listed on the front cover of this booklet).

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Section

Your Plan contacts (how to contact us, including how to reach Customer Service at your plan)

1.

How to contact your plan's Customer Service

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

Customer Service

Call 1-866-470-6265

8 a.m. to 8 p.m., 7 days a week.

Calls to this number are free.

TTY 1-877-247-1657

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Write Anthem Blue Cross MedicareRx

P.O. Box 110

Fond du Lac, Wisconsin 54936

Website www.anthem.com/ca

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

You may call us if you have questions about our coverage decision, appeals, or complaint processes.

Coverage Decisions, Appeals, or Complaints for Part D Prescription Drugs

Call 1-866-470-6265

Calls to this number are free.

TTY 1-877-247-1657

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Fax 1-888-458-1407

Write Anthem Blue Cross MedicareRx

P.O. Box 1975

Fond du Lac, Wisconsin 54936

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For more information on asking for coverage decisions, appeals, or complaints about your Part D prescription drugs, see Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

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

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

Payment Requests
.....**Call 1-866-470-6265**

Calls to this number are free.

TTY 1-877-247-1657

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Fax 1-888-458-1407**Write Anthem Blue Cross MedicareRx**

P.O. Box 110

Fond du Lac, Wisconsin 54936

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

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Prescription Drug Plans, including us.

Section
(con't)**Medicare****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 www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting “Helpful Phone Numbers and Websites.”

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.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. The State Health Insurance Assistance Program (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.

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

Section
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problems with your Medicare bills. Counselors can also help you understand your Medicare plan choices and answer questions about switching plans. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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

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

You should contact the Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

For contact information, please refer to the state specific agency listing located in the back of this booklet.

5. **Social Security**

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare and pay the Part B premium. 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 Administration

Call 1-800-772-1213

Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use the automated telephone services to get recorded information and conduct some business 24 hours a day.

Section
(con't)**TTY 1-800-325-0778**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.

Website <http://www.ssa.gov>

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. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, please refer to the state specific agency listing located in the back of this booklet.

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

Medicare's "Extra Help" Program

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

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

If you qualify for Extra Help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" (LIS Rider) that explains your costs as a member of this plan. If the amount of your Extra Help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" (LIS Rider).

Section
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If you think you may qualify for Extra Help, call Social Security (see the state specific agency listing located in the back of this booklet for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see the state specific agency listing located in the back of this booklet for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Pharmaceutical Assistance Programs

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

The State Pharmaceutical Assistance Program is a state organization that provides limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. For contact information, please refer to the state specific agency listing located in the back of this booklet.

8. How to contact the Railroad Retirement Board

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

Railroad Retirement Board

Call 1-877-772-5772

Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY 1-312-751-4701

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are not free.

Website <http://www.rrb.gov>

Section

9. Do you have “group insurance” or other health insurance from another employer?

If you have other prescription drug coverage through your (or your spouse’s) employer or retiree group, please contact **that group’s benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with this plan.

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Section
Q/A**Did you know there are programs to help people pay for their drugs?**

The “Extra Help” program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage may not apply to you.** If you qualify for Extra Help, we will send you by mail an “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), that tells you about your drug coverage. If you don't have this rider, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are listed on the front cover of this booklet.

1. Introduction**1.1****This chapter describes your coverage for Part D drugs**

This chapter explains rules for using your coverage for Part D drugs under your plan. The next chapter tells what you pay for Part D drugs (Chapter 4, What you pay for your Part D prescription drugs?).

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

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

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

Section

1.2

Basic rules for your plan's Part D drug coverage

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

- You must use a network pharmacy to fill your prescription. (See Section 2, Fill your prescriptions at a network pharmacy.)
- If your plan has a Closed Formulary (Closed Drug List), your drug must be on your plan's Drug List. (See Section 3, Your drugs need to be on your plan's drug list.)
- If your plan has an Open Formulary (Open Drug List), you have coverage for additional drugs not in your drug list. Drugs not listed will be covered unless they are excluded because of safety concerns, statutory restrictions or are typically not covered by drug plan benefits. (See the Benefit Chart located in the front of this booklet to find out if you have an Open Formulary plan.)

Your drug must be considered “medically necessary,” meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

2.

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

2.1

To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at your plan's network pharmacies.

A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term “covered drugs” means all of the Part D prescription drugs that are covered by your plan.

2.2

Finding network pharmacies**How do you find a network pharmacy in your area?**

You can look in your Pharmacy Directory, or call Customer Service (phone numbers are listed on the front cover of this booklet). 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 to either have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

Section
(con't)**What if the pharmacy you have been using leaves the network?**

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

What if you need a non-retail, network pharmacy?

Sometimes prescriptions must be filled at a non-retail, network pharmacy. Non-retail, network pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care 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 certain drugs that are restricted by the FDA to certain locations require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate a non-retail, network pharmacy, look in your Pharmacy Directory or call Customer Service (phone numbers are listed on the front cover of this booklet).

2.3

Using your plan's mail-order services

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

To get order forms and information about filling your prescriptions by mail simply call Customer Service. If you use a mail-order pharmacy not in your plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 12 days. However, sometimes your mail-order may be delayed. If your mail-order is delayed, we will notify you and provide instructions on how to obtain your prescription in the interim.

Section

2.4

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

When you get a long-term supply of drugs, your cost sharing may be lower. Your plan offers two ways to get a long-term supply of “mail-order” drugs on your plan’s Drug List. (Mail-order 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 mail-order drugs. You are not required to use the mail-order service to get a longer term supply of mail-order drugs. If you get a longer term supply of mail-order drugs at a retail network pharmacy, your cost sharing may be different than it is for a longer term supply from the mail-order service. Please check the Benefit Chart located in the front of this booklet to find out what your costs will be if you get a longer term supply from a retail pharmacy. You can also call Customer Service for more information.
2. For all kinds of drugs, you can use your plan’s network mail-order services. Your plan’s mail-order service requires you to order up to a 90-day supply for most drugs. Specialty drugs are only available in a 30-day supply on most plans. Please check the Benefit Chart located in the front of this booklet to verify the maximum day supply limits in your plan for mail-order drugs. See Section 2.3 for more information about using your mail-order services.

2.5

When can you use a pharmacy that is not in your plan’s network?

Your prescription might 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:

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

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

Section
(con't)

- The prescription is for a medical emergency or urgent care.
- The pharmacy is not located outside the United States or its Territories.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy in the area where you are traveling within the United States.

How do you ask for reimbursement from your plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying 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 your plan to pay you back.)

In addition to paying the copayments/coinsurances listed on the Benefit Chart located in the front of this booklet, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

3. If you have a closed formulary plan, your drugs need to be on your plan's "Drug List"

3.1

The "Drug List" tells which Part D drugs are covered

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

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

We will generally cover a drug on your plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

Your drug list includes both brand-name and generic drugs

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

Section
(con't)**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.

3.2

How do “cost-sharing tiers” for drugs on the Drug List impact my cost?

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

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

The amount you pay for drugs in each cost-sharing tier is also shown in the Benefit Chart located in the front of this booklet.

3.3

How can you find out if a specific drug is on your drug list?

You have two ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Call Customer Service to find out if a particular drug is on your plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are listed on the front cover of this booklet.

4.

There are restrictions on coverage for some drugs

4.1

Why do some drugs have restrictions?

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

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

Section

4.2

What kinds of restrictions?

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

Using generic drugs whenever you can

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

Getting plan approval in advance

For certain drugs, you or your doctor need to get approval from us before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by your plan.

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, we 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.

4.3

Do any of these restrictions apply to your drugs?

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

Section

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

5.

5.1

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

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by your plan?** 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.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by your plan have extra rules to restrict their use. For example, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** Your plan puts each covered drug into one cost-sharing tier. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

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

5.2

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

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

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply) until you and your doctor decide it is okay to change to another drug, or while you file an exception.
- 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 covered.

Section
(con't)**You may be able to get a temporary supply**

Under certain circumstances, your plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your 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:

- If you are on a Closed Formulary plan, the drug you have been taking is **no longer on your plan's Drug List**.
- Or for all plans, the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

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

- **For those members who were in this plan last year:**

We will cover a temporary supply of your drug **one time only during the first 90 days of the benefit year**. This temporary supply will be for a maximum of 30-days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to this plan and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in this plan. This temporary supply will be for a maximum of 30-days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those who are new members, and are residents in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in this plan. The first supply will be for a maximum of 34-days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in this plan.

- **For those who have been a member of this plan for more than 90 days, and are a resident of a long-term care facility and need a supply right away:**

We will cover one 34-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call Customer Service (phone numbers are listed on the front cover of this booklet).

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During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by your plan that might work just as well for you. Or you and your doctor can ask us to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug covered by your plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

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

If you and your doctor or other prescriber want to ask for an exception, Chapter 7 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.

5.3

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

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

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor or other prescriber to find a covered drug that might work for you.

You can file an exception

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

Section
(con't)

If you and your doctor or other prescriber want to ask for an exception, Chapter 7 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.

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

6.1

The Drug List can change during the year

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

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

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

6.2

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

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

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

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, we will immediately remove the drug from your 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.

Do changes to your drug coverage affect you right away?

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

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

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

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

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

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

7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." Excluded means that your plan doesn't cover these types of drugs because the law doesn't allow any Medicare drug plan to cover them.

If you get drugs that are excluded, you must pay for them yourself, or they may be covered under your medical plan.

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

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

Also, by law, these categories of drugs are not covered by Medicare drug plans unless your plan covers them as "Extra Covered Drug Groups". Please see the "Extra Covered Drug Groups" section of the Benefit Chart located in the front of this booklet to find out which of the drugs listed below are covered under your plan.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- 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
- Barbiturates and Benzodiazepines

If you have coverage for some prescription drugs not normally covered in a Medicare Prescription Drug Plan, shown in the "Extra Covered Drug Groups" section of the Benefit Chart located in the front of this booklet, the amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.)

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In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help will not pay for the drugs not normally covered. (Please refer to your formulary or call Customer Service for more information.) However, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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

8.1 Show your membership card

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

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

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

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

9. Part D drug coverage in special situations

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

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

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

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 8, Ending your membership in your plan, tells you how you can leave your plan and join a different Medicare plan.)

9.2

What if you're a resident in a long-term care facility?

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

Check your Pharmacy Directory to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Customer Service.

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

If you need a drug that is not on your Drug List or is restricted in some way, we will cover a temporary supply of your drug during the first 90 days of your membership. The first supply will be for a maximum of 34 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in your plan.

If you have been a member of your plan for more than 90 days and need a drug that is not on your Drug List or if your plan has any restriction on the drug's coverage, we will cover one 34-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 or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by your plan that might work just as well for you. Or you and your doctor can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, Chapter 7 tells what to do.

Section

9.3

What if you are taking drugs covered by Original Medicare?

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

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

9.4

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

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

Each year your Medigap insurance company should send you a notice by November 15 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 has drug coverage that pays, on average, at least as much as Medicare's standard 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 Medicare insurance company and ask for another copy.

9.5

What if you're also getting drug coverage from another employer or retiree group plan?

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

Section

10. Programs on drug safety and managing medications**10.1****Programs to help members use drugs safely.**

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

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

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

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

10.2**Programs to help members manage their medications**

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

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Section
Q/A**Did you know there are programs to help people pay for their drugs?**

The “Extra Help” program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage may not apply to you.** You will be mailed the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider) that tells you about your drug coverage. If you don’t have this rider, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are listed on the front cover of this booklet.

1. Introduction**1.1****Use this chapter together with other materials that explain your drug coverage**

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 3, some drugs are covered under Original Medicare or are excluded by law. Some excluded drugs may be covered by your plan. To find out which extra covered drug groups are covered by your plan, please look at the Benefit Chart located in the front of this booklet. To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **Your plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.

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- It also tells which of the “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
- If you need a copy of your drug list, call Customer Service (phone numbers are listed on the front cover of this booklet).
- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by your plan.
- **Your plan’s Pharmacy Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The Pharmacy Directory has a list of pharmacies in your plan’s network and it tells how you can use your plan’s mail-order service. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three month’s supply).

We send you reports that explain payments for your drugs

2.1

We send you a monthly report called the “Explanation of Benefits”

Your plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. In particular, there are two types of costs we keep track of:

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

Your plan will prepare a written report called the Explanation of Benefits (it is sometimes called the “EOB”) when you have had one or more prescriptions filled. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what your plan paid, and what you and others on your behalf paid.
- **Totals for the benefit year used by your group plan (see dates on the first page of this booklet).** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

Section

2.2

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

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need. To 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 your plan to pay its share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of your plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Check the written report we send you.** When you receive an Explanation of Benefits in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are listed on the front cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

Section

The plan pays its share of your drug costs and you pay your share

3.1

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

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

Your plan has Cost-Sharing Tiers

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

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

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

Your pharmacy choices

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

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

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

Section

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

4.

4.1

Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your 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 5 of this booklet):

- The amount you pay for drugs during the Initial Coverage period.

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, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by "Extra Help" from Medicare are also included.

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

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

- The amount you, or others on your behalf, pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by your plan.
- Drugs you get at an out-of-network pharmacy that do not meet the requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by insurance plans and government-funded health programs such as TRICARE, the Veteran's Administration, the Indian Health Service, or AIDS Drug Assistance Programs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's 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 us. Call Customer Service to let us know (phone numbers are listed on the front cover of this booklet).

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

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

Section

5. Catastrophic Coverage

5.1 Once you qualify for Catastrophic Coverage, your plan pays for most of the cost for your drugs

You qualify for Catastrophic Coverage when you have reached your out-of-pocket limit for the benefit year. Once you qualify for Catastrophic Coverage, your plan will pay most of the cost for your drugs until the end of the benefit year selected by your (or your spouse's) former employer.

You can find your cost sharing amounts in the Catastrophic Coverage section of the Benefit Chart located in the front of this booklet.

6. Additional benefits information

6.1 Your plan offers additional benefits

We provide additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your out of pocket costs. You can find the additional types of drugs covered by your plan in the “Extra Covered Drug Groups” section of the Benefit Chart located in the front of this booklet. You can find out which specific drugs are covered by checking your “Drug List”.

7. What you pay for vaccinations depends on how and where you get them

7.1 Your plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

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

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

Section
(con't)**What do you pay for a vaccination?**

What you pay for a vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered Part D drugs. You can find these vaccines listed in your plan's List of Covered Drugs.
- 2. Where you get the vaccine medication.**
- 3. Who gives you the vaccination shot?**

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

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

To show how this works, here are three common ways you might get a vaccination shot.

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

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and administration of the vaccine.

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

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

Section
(con't)**Situation 3: You buy the vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.**

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask your plan to pay its share of the cost by using the procedures described in Chapter 5 of this booklet.
- You will be reimbursed the amount charged by the doctor less the amount for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

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

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

Anthem Blue Cross MedicareRx
P.O. Box 145613
Cincinnati, OH 45250-5613

We can help you understand the costs associated with vaccines (including administration) available under this plan, especially before you go to your doctor. For more information, please contact Customer Service (phone numbers are listed on the front cover of this booklet).

7.2

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

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

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

Section

Do you have to pay the Part D

8. “late enrollment penalty”?

8.1

What is the Part D “late enrollment penalty”?

You 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 keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to the monthly premium charged to your (or your spouse's) former employer for your coverage. If you think you may have a late enrollment penalty, you should contact your (or your spouse's) former employer to see what amount you will have to pay.

8.2

How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have credible 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, let's say it is 14 months without coverage, which will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2009, this average premium amount was \$30.36. This amount may change for 2010.
- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents. In the example here it would be 14% times \$30.36, which equals \$4.25, which rounds to \$4.30. This amount would be added **to the monthly premium for someone with a late enrollment penalty.**

There are three important things to note about this monthly premium 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.

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- 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 under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for Medicare.

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

8.3

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

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

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

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this "**creditable drug coverage.**" Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is as at least as good as Medicare's.
- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days in a row.
- If you didn't receive enough information to know whether or not your previous drug coverage was creditable.
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) – and – you signed up for a Medicare prescription drug plan by December 31, 2006 – and – you have stayed in a Medicare prescription drug plan.
- You are receiving Extra Help from Medicare.

8.4

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

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Customer Service at the number listed on the front of this booklet to find out more about how to do this.

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Section

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

1.

1.1

If you pay your 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 your plan to pay you back (paying you back is often called “reimbursing” you). Asking for reimbursement in the first three examples below are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

Here are examples of situations in which you may need to ask your plan to pay you back:

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

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

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

If you do not have your plan membership card with you 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 your plan to get your member information, but there may be times when you may need to pay if you do not have your card.

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

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

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

- For example, the drug may not be on your plan's List of Covered Drugs (Formulary); or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

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- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

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

2. How to ask your plan to pay you back

2.1 How and where to send us your request for payment

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

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

- You don't have to use the form, but it's helpful for your plan to process the information faster.

Please contact Customer Service and ask for the form. See Chapter 2 for information about how to contact Customer Service.

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

Anthem Blue Cross MedicareRx
P.O. Box 110
Fond du Lac, Wisconsin 54936

Please be sure to contact Customer Service if you have any questions. If you don't know what you owe, 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.

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

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 decide whether to pay it and how much we owe.

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- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of all but your share to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs.)
- 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.

3.2

If we tell you that we will not pay for the drug, you can make an appeal

If you think we have made a mistake in turning you down, 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. These are examples of situations in which you may need to ask your plan to pay you back:

- When you use an out-of-network pharmacy to get a prescription filled.
- When you pay the full cost for a prescription because you don't have your plan membership 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 of this booklet (What to do if you have a problem or complaint? coverage decisions, appeals, complaints). The appeals process is a legal 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 in Chapter 7 for a step-by-step explanation of how to file an appeal.

4.

Other situations in which you should save your receipts and send them to this plan

4.1

In some cases, you should send your receipts to this plan 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 Catastrophic Coverage more quickly.

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Here are two situations when you should send us 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 the plan's price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside the plan's benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on your Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

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

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

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

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

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Section

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

1.

1.1

We must provide information in a way that works for you (including languages other than English that are spoken in the plan service area and large print)

To get information from us in a way that works for you, please call Customer Service (phone numbers are listed on the front cover of this booklet).

Your plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in large print if you need it. If you are eligible for Medicare because of disability, we are required to give you information about your plan's benefits that is accessible and appropriate for you.

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

1.2

We must treat you with fairness and respect at all times

Your plan must obey laws that protect you from discrimination or unfair treatment.

We do not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

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** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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

1.3

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

As a member of this 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 of this booklet tells what you can do.

Section

1.4

We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and 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 front cover of this booklet).

Section
(con't)**HIPAA Notice of Privacy Practices – Effective July 1, 2007**

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

Your Protected Health Information

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

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

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

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

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons and to coroners, funeral directors or medical examiners (about decedents).

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PHI can also be shared for certain reasons with organ donation groups for research and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

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

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request.

They can also give you any forms we have that may help you with this process.

How We Protect Information

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

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We keep your oral, written and electronic PHI safe using physical, electronic and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job.

Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

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

Complaints

If you think we have not protected your privacy, you can file a complaint with us.

You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

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

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time.

We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

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Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following company: Anthem Blue Cross.

State Notice of Privacy Practices – Effective July 1, 2007

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

Your Personal Information

We may collect, use and share your non-public personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit. We may collect PI about you from other persons or entities such as doctors, hospitals or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone Customer Service (phone numbers are listed on the front cover of this booklet).

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following company: Anthem Blue Cross.

Section

1.5

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

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

If you want any of the following kinds of information, please call Customer Service (phone numbers are listed on the front cover of this booklet):

- **Information about your plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Prescription Drug plans.
- **Information about our network pharmacies.**
 - For example, you have the right to get information from us about the pharmacies in our network.
 - For a list of the pharmacies in your plan's network, see the Pharmacy Directory.
 - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are listed on the front cover of this booklet).
- **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 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the 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 front cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
 - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you

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the details about how to ask your plan for a decision about your coverage and 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 your plan to pay its share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

1.6

We must support your right to make decisions about your care

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

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

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

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

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

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

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

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- 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 state-specific agency (such as the State Department of Health). For contact information, please refer to the state specific agency listing located in the back of this booklet.

1.7

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

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

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 your plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint.

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

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

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,

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you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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 front cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization, go to Chapter 2, Section 3. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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 front cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization, go to Chapter 2, Section 3. For contact information, please refer to the state specific agency listing located in the back of this booklet.
- You can contact **Medicare**.
 - You can visit the Medicare website (<http://www.medicare.gov>) to read or download the publication "Your Medicare Rights & Protections."
 - 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.

You have some responsibilities as a member of this plan

2.

2.1

What are your responsibilities?

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

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- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
 - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage besides this plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are listed on the front cover of this booklet).
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from 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.
- **Tell your doctor and pharmacist that you are enrolled in this plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health 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.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums, if any, to your (or your spouse’s) former employer or union (or, if you are billed directly, you must send your payment to the address listed on your billing statement), to continue being a member of your plan.
 - For some of your drugs covered by your plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). You can find this information listed on the Benefit Chart located in the front of this booklet.
 - If you get any drugs that are not covered by your plan or by other insurance you may have, you must pay the full cost.

Section
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- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are listed on the front cover of this booklet).
 - **If you move outside of the plan service area, you cannot remain a member of the plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - **If you move within the service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving your plan.
 - Phone numbers and calling hours for Customer Service are listed on the front cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

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Section

BACKGROUND**1. Introduction****1.1****What to do if you have a problem or concern****Please call us first**

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

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

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of your plan.

This chapter explains two types of formal processes for handling problems:

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

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

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

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 more common words in place of certain legal terms. For example, this chapter generally

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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.

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

2.

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. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you, but in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program**.

This government program has trained counselors in every state. The program is not connected with your plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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 (<http://www.medicare.gov>).

Section

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

3.

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 and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter tells what to do for your problem or concern, **START HERE**

Is your problem or concern about your benefits and 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

NO

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

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

4.

A guide to the basics of coverage decisions and appeals

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.

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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 make a coverage decision for you whenever you fill a prescription at a pharmacy.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the drug is covered and pay our share of the cost.
- But in some cases we might decide the 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 make an appeal we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

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

4.2

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

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

- You **can call Customer Service** (phone numbers are listed on the front cover of this booklet).
- To **get free help from an independent organization** that is not connected with your plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter). For contact information, please refer to the state specific agency listing located in the back of this booklet.

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- **You should consider getting your doctor or other prescriber involved if possible, especially if you want a “fast” or “expedited” decision.** In most situations involving a coverage decision or appeal, your doctor or other prescriber must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with your plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your “representative” (see below about “representatives”).
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Service and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give your plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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.

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 this plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in your plan’s List of Covered Drugs (Formulary)

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and they are medically necessary for you, as determined by your primary care doctor or other provider.

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

Part D coverage decisions and appeals

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

Legal Terms

A coverage decision is often called an **“initial determination”** or “initial decision.” When the coverage decision is about your Part D drugs, the initial determination is called a **“coverage determination.”**

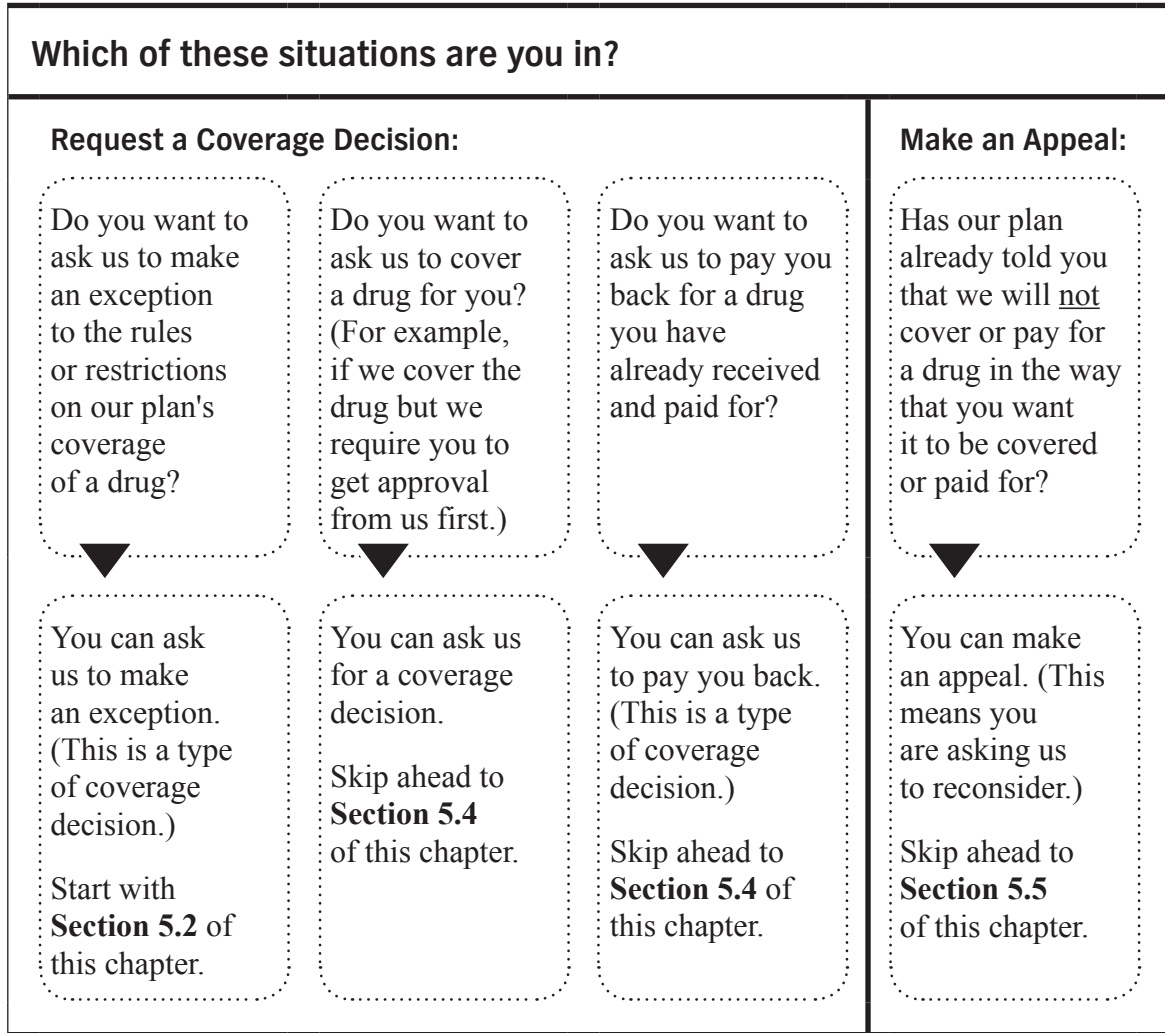
Here are examples of coverage decisions you ask us to make about your Part D drugs:

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

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(con't)



5.2

What is an exception?

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

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

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

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

- If we agree to make an exception and cover a drug that is not on your drug list, you will need to pay the cost-sharing amount that applies to all of our drugs OR drugs in the non-preferred brand tier. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
- You cannot ask 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 the plan's coverage for a covered drug.

There are extra rules or restrictions that apply to certain drugs on your plan's List of Covered Drugs (for more information, go to Chapter 3).

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

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

3. Changing coverage of a drug to a lower cost-sharing tier.

Every drug on your plan's Drug List is in one of the cost-sharing tiers. The cost sharing tiers used in your plan are shown in the Benefit Chart located in the front of this booklet. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

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

- If your drug is in the non-preferred brand tier you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred brand tier. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in the Specialty Drug tier.

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

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

Our plan can say yes or no to your request

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

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

5.4

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

Step

1. 

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

Section
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What to do:

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing your plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the topic called, How to contact us when you are asking for a coverage decision, appeal, or complaint about your Part D prescription drugs. Or if you are asking us to pay you back for a drug, go to the topic called, Where to send a request that asks us to pay for our share of the cost for medical care or 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 representative. You can also have a lawyer act on your behalf.
- **If you want to ask your plan to pay you back for a drug,** start by reading Chapter 5 of this booklet: Asking your plan to pay its share of a bill you have received for medical services or 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 “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor or other prescriber can fax or mail the statement to your plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 5.2 and 5.3 for more information about exception requests.

If your health requires it, ask us to give you a “fast decision”:

.....
Legal A “fast decision” is called an
Terms “expedited decision.”
.....

- 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.

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- **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 are 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), your plan 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. (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. **Our plan considers your request and we give you our answer.**

Deadlines for a “fast” coverage decision:

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we 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.

Section
(con't)Deadlines for a “**standard**” coverage decision:

- 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 we approve your request to pay you back for a drug you already bought, we are also required to **send payment to you within 30 calendar days** 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.

Step

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

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

5.5

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

When you start the appeals process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”

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

Step

1. ▶

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

What to do:

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact your plan.**
 - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the topic called, How to contact us when you are asking for a coverage decision, appeal, or complaint about your Part D prescription drugs.
- **Make your appeal in writing by submitting a signed request.**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer 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.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”:

Legal Terms

A “fast appeal” is also called an **“expedited appeal.”**

- If you are appealing a decision your plan 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. ▶

Our plan considers 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 being fair and 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.

Section
(con't)**Deadlines for a “fast” appeal:**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we 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.
- **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 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.
 - 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 your 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 your 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 your 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.**”

Level 2 Appeal

Step

1. ▶

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

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

Section
(con't)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.”)

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 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 if the dollar value of the coverage you are requesting is high enough 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.

6. Taking your appeal to Level 3 and beyond

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 who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal

A judge who works for the federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative judge says no to your appeal, the

Section
(con't)

notice you get will tell you what to do next if you choose to continue with your appeal. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 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.
- **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. It depends on your situation. 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 who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

A judge at the Federal District Court will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS**7. How to make a complaint about quality of care, waiting times, customer service, or other concerns**

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

Section

7.1

What kinds of problems are handled by the complaint process?

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

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

Quality of your medical care

- Are you unhappy with the quality of the care you have received?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Service department has dealt with you?
- Do you feel you are being encouraged to leave our plan?

Waiting times

- Have you been kept waiting too long by pharmacists? Or by Customer Service or other staff at our plan?
- Examples include waiting too long on the phone or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a pharmacy?

Information you get from our plan

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

(The next page has more examples of possible reasons for making a complaint)

Section
(con't)**Possible complaints**
(continued)**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 for a coverage decision or made an appeal, and you think that our plan is 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 our plan is 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 our plan is 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 our plan does 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.

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

1.

Step-by-step: Making a complaint**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. See Chapter 2 for information about how to contact Customer Service.

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 do this, it means that we will use our formal procedure for answering grievances. Here's how it works:

- You or someone you name may file a grievance. The person you name would be your “representative.” You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the court or in accordance with state law to act for you. If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service (phone numbers are listed on the front cover of this booklet).
- A grievance must be filed either verbally or in writing within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.

Whether you call or write, you should contact Customer Service right away.

The complaint must be made within 60 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 a “fast 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 days, but we may take up to 44 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 days (44 days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

7.4

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

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to your plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, please refer to the state specific agency listing located in the back of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to your plan and also to the Quality Improvement Organization.

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Section

1. Introduction**1.1****This chapter focuses on ending your membership in your plan**

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

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

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

2. When can you end your membership in your plan?

You may end your membership in your plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave your plan during the Annual Enrollment Period. In certain situations, you may also be eligible to leave your plan at other times of the year.

2.1**Usually, you can end your membership during the Annual Enrollment Period for Individual (non-group) Plans**

You can end your membership during the **Annual Enrollment Period for Individual (non-group) Plans** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period for Individual (non-group) Plans?**
This happens every year from November 15 to December 31.
- What type of plan can you switch to during the Annual Enrollment Period for Individual (non-group) Plans? During this time, you can review your health

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coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- An Individual (non-group) Medicare prescription drug plan.
- Original Medicare *without* a separate Medicare prescription drug plan.
- *Or*, an Individual (non-group) Medicare Advantage plan. A Medicare Advantage plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage plans also include Part D prescription drug coverage.
- **Ending your employer sponsored Medicare Part D plan may impact your eligibility for other coverage sponsored by your employer or mean that you will not be able to re-enroll in the employer plan in the future. Before ending your employer sponsored Medicare Part D coverage, please contact your (or your spouse's) former employer.**

Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is at least as good as Medicare’s standard prescription drug coverage.)

- **When will your employer or union sponsored Part D plan membership end?** Your membership will end when your Individual (non-group) plan’s coverage begins on January 1.

2.2

You can end your membership during the Medicare Advantage Open Enrollment Period for Individual (non-group) Plans, but your plan choices are more limited

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period for Individual (non-group) Plans.**

- **When is the Medicare Advantage Open Enrollment Period for Individual (non-group) Plans?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the Medicare Advantage Open Enrollment Period for Individual (non-group) Plans?** During this time, you can make *one* change to your health plan coverage. However, you may *not* add or drop prescription drug coverage during this time. Since you are currently enrolled in a Medicare prescription drug plan, this means that you can enroll in:
 - An Individual (non-group) Medicare Advantage plan with prescription drug coverage. (A Medicare Advantage plan is a plan offered by a private

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company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits.)

- **Ending your employer sponsored Medicare Part D plan may impact your eligibility for other coverage sponsored by your employer or mean that you will not be able to re-enroll in the employer plan in the future. Before ending your employer sponsored Medicare Part D coverage, please contact your (or your spouse's) former employer.**
- **When will your employer or union Part D plan membership end?** Your membership will end on the first day of the month after we get your request to change plans.

2.3

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

Employer or union sponsored plans may allow changes to their retiree's enrollment at:

- The Employer's open enrollment period, this may be any time of the year and does not have to coincide with the individual open enrollment period from 11/15-12/31
- **Please check with your (or your spouse's) former employer for additional enrollment and disenrollment options, and the impact of any changes to your employer sponsored retiree benefits**

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

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact us, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - If you have permanently moved outside of the United States
 - If you have Medicaid.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.
 - If you live in a facility, such as a nursing home.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:

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- An Individual (non-group) Medicare prescription drug plan.
- Original Medicare *without* a separate Medicare prescription drug plan.
- – *Or* – An Individual (non-group) Medicare Advantage plan. A Medicare Advantage plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage plans also include Part D prescription drug coverage.
- **Ending your employer sponsored Medicare Part D plan may impact your eligibility for other coverage sponsored by your employer or mean that you will not be able to re-enroll in the employer plan in the future. Before ending your employer sponsored Medicare Part D coverage, please contact your (or your spouse's) former employer**

Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is at least as good as Medicare’s standard prescription drug coverage.)

- **When will your employer or union Part D plan membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

2.4

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

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

- First contact your (or your spouse's) former employer's group benefit administrator to get information on options available to you.
- You can **call Customer Service** (phone numbers are listed on the front cover of this booklet).
- You can find the information in the *Medicare & You 2010* 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 (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section

How do you end your membership in your employer or union sponsored Part D plan?

3.

3.1

You end your membership by enrolling in another plan

Usually, to end your membership in your employer or union sponsored Part D plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods).

If you want to switch from your employer or union sponsored Part D plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact Customer Service (phone numbers are listed on the front cover of this booklet) and ask to be disenrolled from your plan.

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

| If you would like to switch from your plan to: | This is what you should do: |
|--|---|
| <p>An Individual (non-group) Medicare prescription drug plan.</p> | <ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from your employer or union sponsored plan when your Individual plan's coverage begins. |
| <p>An Individual (non-group) Medicare Advantage plan.</p> | <ul style="list-style-type: none"> • Enroll in the Medicare Advantage plan. With most Medicare Advantage plans, you will automatically be disenrolled from your employer or union sponsored plan when your Individual plan's coverage begins. If you want to leave your plan, you must <i>either</i> enroll in another Medicare prescription drug plan <i>or</i> contact Customer Service (phone numbers are listed on the front cover of this booklet) or Medicare and ask to be disenrolled. |
| <p>Original Medicare <i>without</i> a separate Medicare prescription drug plan.</p> | <ul style="list-style-type: none"> • Contact Customer Service and ask to be disenrolled from your plan (phone numbers are on the cover of this booklet). • You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users should call 1-877-486-2048. |

Section

Until your membership ends, you must keep getting your drugs through your employer or union sponsored Part D plan

4.

4.1

Until your membership ends, you are still a member of your employer or union sponsored Part D plan

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

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

We must end your membership in your plan in certain situations

5.

5.1

When must we end your membership in your plan?

We must end your membership in your plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move outside the United States.
- If you 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.
- 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 your plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

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- If your former employer notifies us that the employer is canceling the group contract for this plan.
- If the premiums for this plan are not paid in a timely manner.

Where can you get more information?

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

- You can call **Customer Service** for more information (phone numbers are listed on the front cover of this booklet).

5.2

We cannot ask you to leave your plan for any reason related to your health**What should you do if this happens?**

If you feel that you are being asked to leave your plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

5.3

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

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

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Section

1. Notice about governing law

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

2. Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage 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, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

Definitions of important words

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if your Plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have paid your true out of pocket cost for covered drugs during the covered year. You can find this amount listed on the Benefit Chart located in the front of this booklet.

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

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed “copayment” amounts that a plan may require be paid when specific drugs are received; or (3) any “coinsurance” amount that must be paid as a percentage of the total amount paid for a drug.

Cost-sharing Tier – Every drug on the list of covered drugs is in one cost-sharing tier. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by your plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription is not covered under your plan, that is not a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

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

Creditable Prescription Drug

Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Customer Service – A department within your Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Deductible – The amount you must pay before your Plan begins to pay its share of your covered drugs.

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

Evidence of Coverage (EOC)

and Disclosure Information –

This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of this Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or your plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by your plan.

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

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 maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage after you have met your deductible (if you have one) and before your total drug expenses, have reached your initial coverage limit, including amounts you’ve paid and what we have paid on your behalf.

To find out if your plan includes an initial coverage limit, refer to the Benefit Chart located in the front of this booklet.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects 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.

List of Covered Drugs (Formulary or “Drug List”) – A list of covered drugs provided by your plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy/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.

Medically Necessary – Drugs that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by your Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare 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 us. 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 government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered

by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

Part C – see “Medicare Advantage (MA) Plan”.

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

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2 for information about the QIO in your state and Chapter 7 for information about making complaints to the QIO. For contact information, please refer to the state specific agency listing located in the back of this booklet.

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

Select Generics - A specific list of generic drugs that have been on the market long enough to have a proven track record for effectiveness and value. A complete list of these drugs is included in your drug list (Formulary) that accompanies this Evidence of Coverage. Some plans have reduced copayments for Select Generics. If your plan includes a reduced copayment, you can find this information listed on the Benefit Chart located in the front of this booklet.

Service Area – “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

Specialty drugs – The Centers for Medicare & Medicaid Services (CMS) defines specialty drugs as any drug that costs \$600 or more per unit.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by 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.

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Section

1. State Health Insurance Assistance (SHIP)

ALABAMA

Alabama Department of Senior Services

770 Washington Avenue, RSA Plaza,
Suite 470
Montgomery, AL 36130-1851
1-800-AGELINE; 1-334-242-5743
TTY/TDD: 711
www.adss.state.al.us/

ALASKA

Department of Health & Social Services Division of Senior & Disabilities Services

31-601 C Street, Suite 310
Anchorage, AK 99503
1-800-478-6065
TTY/TDD: 711
www.hss.state.ak.us/dsds/medicare/

ARIZONA

Arizona Department of Economic Security

1789 West Jefferson, Suite 950A
Phoenix, AZ 85007
1-800-432-4040
TTY/TDD: 711
<https://egov.azdes.gov/cmsinternet/>

ARKANSAS

Arkansas Insurance Department

1200 West Third Street,
Little Rock, AR 72201
1-800-224-6330; 1-501-371-2782
TTY/TDD: 711
<http://insurance.arkansas.gov/seniors/homepage.htm>

CALIFORNIA

California Department of Aging

1300 National Drive, Suite 200
Sacramento, CA 95834-1992
1-800-434-0222
TTY/TDD: 1-800-735-2929

Health Insurance Counseling and Advocacy Program HICAP of California

1600 K Street,
Sacramento, CA 95814
1-800-434-0222
TTY/TDD: 711
www.aging.ca.gov/information_on/hicap.asp

COLORADO

Department of Regulatory Agencies

1560 Broadway, Suite 1550
Denver, CO 80202
1-888-696-7213
TTY/TDD: 1-303-894-7880
www.dora.state.co.us/insurance/

CONNECTICUT

Connecticut Department of Social Services

25 Sigourney Street, 10th Floor
Hartford, CT 06106
1-800-994-9422
TTY/TDD: 1-860-424-5274
www.ct.gov/agingervices/site/

Section

1. State Health Insurance Assistance (SHIP) (con't)

DELAWARE

ELDERinfo

841 Silver Lake Boulevard,
Dover, DE 19904

1-800-336-9500

TTY/TDD: 711

<http://delawareinsurance.gov/departments/elder/>

DISTRICT OF COLUMBIA

District of Columbia Office on Aging

441 4th Street NW, Suite 900S
Washington, DC 20739-0668

1-202-739-0668

TTY/TDD: 1-202-973-1079

www.dcoa.dc.gov/

FLORIDA

Florida Department of Elder Affairs

4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000

1-800-963-5337

TTY/TDD: 1-850-414-2001

www.floridashine.org/

GEORGIA

GeorgiaCares

2 Peachtree Street NW, 36th floor
Atlanta, GA 30303

1-800-669-8387; 1-404-657-5334

TTY/TDD: 711

www.dhr.georgia.gov/

HAWAII

Executive Office on Aging Department of Health

250 S. Hotel Street, Suite 406
Honolulu, HI 96813

1-888-875-9229; 1-808-586-0100

TTY/TDD: 711

<http://hawaii.gov/health/ea/>

IDAHO

State of Idaho Department of Insurance

P.O. Box 83720, 700 West State Street
Boise, ID 83720-0043

1-800-247-4422; 1-208-334-4250

TTY/TDD: 711

www.doi.idaho.gov

ILLINOIS

Illinois Division of Insurance

320 W. Washington 4th Floor
Springfield, IL 62767

1-800-548-9034; 1-217-782-4515

TTY/TDD: 1-217-524-4872

<http://insurance.illinois.gov>

INDIANA

State Health Insurance Assistance Program

311 West Washington St, Suite 300
Indianapolis, IN 46204

1-800-452-4800; 1-765-608-2318

TTY/TDD: 1-800-743-3333

www.in.gov/idoi/2393.htm

Section

1. State Health Insurance Assistance (SHIP) (con't)

IOWA

Senior Health Insurance Information Program

330 Maple
Des Moines, IA 50319

1-800-351-4664

TTY/TDD: 1-800-735-2942

www.shiip.state.ia.us

KANSAS

Kansas Department on Aging

503 S. Kansas
Topeka, KS 66603

1-800-860-5260

TTY/TDD: 711

www.kfmc.org

Senior Health Insurance Counseling for Kansas

503 S. Kansas
Topeka, KS 66603

1-800-432-3535; 1-785-296-4986

TTY/TDD: 1-785-291-3167

www.agingkansas.org

KENTUCKY

State Health Insurance Assistance Program

275 East Main St
Frankfort, KY 40621

1-877-293-7447; 1-502-564-6930

TTY/TDD: 1-800-627-4702

www.chfs.ky.gov

LOUISIANA

Senior Health Insurance Information Program

Louisiana Department of Insurance,
P.O. Box 94214

Baton Rouge, LA 70804

1-800-259-5301; 1-225-342-5900

TTY/TDD: 711

www.ldi.state.la.us

MAINE

Maine State Health Insurance Assistance Program SHIP Office of Elder Services

11 State House Station, 32 Blossom Lane
Augusta, ME 04333

1-800-262-2232; 1-207-287-9200

TTY/TDD: 1-800-606-0215

www.maine.gov/dhhs/oes

MARYLAND

Senior Health Insurance Assistance Program SHIP Maryland Department of Aging

301 W. Preston Street, Suite 1007
Baltimore, MD 21201

1-800-243-3425; 1-410-767-1100

TTY/TDD: 1-800-637-4113

www.mdoa.state.md.us

MASSACHUSETTS

Executive Office of Elder Affairs

One Ashburton Place, 5th floor (The
McCormack Building)
Boston, MA 02108

1-800-243-4636; 1-617-727-7750

TTY/TDD: 1-800-872-0166 (MA Only)

www.800ageinfo.com

Section

1. State Health Insurance Assistance (SHIP) (con't)

MICHIGAN

MMAP Medicare/Medicaid Assistance Program Michigan Office of Services to the Aging

7109 W. Saginaw Highway
Lansing, MI 48917

1-800-803-7174

TTY/TDD: 711

www.seniorresources.us/MMAP.html

MINNESOTA

Minnesota Board on Aging

P.O. Box 64976
St. Paul, MN 55164-0976

1-800-882-6262; 1-651-431-2500

TTY/TDD: 1-800-627-3529

www.mnaging.org

MISSISSIPPI

Mississippi Division of Aging and Adult Services

Mississippi Department of Human Services,
750 N. State St.
Jackson, MS 39202

1-800-345-6347; 1-601-359-4929

TTY/TDD: 1-800-676-4154

www.mdhs.state.ms.us/aas_info.html

MISSOURI

Community Leaders Assisting the Insured of MO CLAIM

200 North Keene Street
Columbia, MO 65210

1-800-390-3330; 1-800-735-2466

TTY/TDD: 711

www.missouriclaim.org

MONTANA

Montana State Health Insurance Assistance Program

111 Sander Street, P.O. Box 4210
Helena, MT 59604

1-800-551-3191; 1-406-444-7788

TTY/TDD: 711

www.dphhs.mt.gov

NEBRASKA

Nebraska Senior Health Insurance Information Program

941 O Street, Suite 400
Lincoln, NE 68508

1-800-234-7119; 1-402-471-2201

TTY/TDD: 1-800-833-7352

www.doi.ne.gov/shiip

NEVADA

State Health Insurance Advisory Program

3416 Goni Road, Suite D #132
Carson City, NV 89706

1-800-307-4444; 1-702-486-3478

TTY/TDD: 711

www.nvaging.net

NEW HAMPSHIRE

New Hampshire ServiceLink Resource Center

129 Pleasant Street State Office Park
Concord, NH 03301-3857

1-866-634-9412

TTY/TDD: 711

www.nh.gov/servicelink/

Section

1. State Health Insurance Assistance (SHIP) (con't)

NEW JERSEY

State Health Insurance Assistance Program

P.O. Box 360
Trenton, NJ 08625-0360
1-800-792-8820; 1-877-222-3737
TTY/TDD: 711
www.state.nj.us/health/senior/ship.htm

NEW MEXICO

Benefits Counseling Program

2550 Cerrillos Road
Santa Fe, NM 87505
1-800-432-2080; 1-505-476-4846
TTY/TDD: 711
www.nmaging.state.nm.us

NEW YORK

**Health Insurance Information Counseling
and Assistance Program New York State
Office for the Aging**

2 Empire State Plaza
Albany, NY 12223-1251
1-800-342-9871
TTY/TDD: 711
www.aging.ny.gov/Index.cfm

Medicare Rights Center

1460 Broadway 17th Floor
New York, NY 10036
1-800-333-4114; 1-212-869-3850
TTY/TDD: 711

NORTH CAROLINA

**Seniors' Health Insurance Information
Program**

11 South Boylan Avenue
Raleigh, NC 27603
1-800-443-9354; 1-919-807-6900
TTY/TDD: 1-919-715-0319
www.ncdoi.com/Consumer/SHIIP/SHIIP.asp

NORTH DAKOTA

**Senior Health Insurance Counseling SHIC
North Dakota Insurance Department**

600 East Boulevard, Fifth Floor
Bismarck, ND 58505-0320
1-800-247-0560; 1-701-328-2440
TTY/TDD: 1-800-366-6888
www.nd.gov/ndins/

OHIO

**The Ohio Senior Health Insurance
Information Program OSHIIP**

50 W. Town Street, 3rd Floor, Suite 300
Columbus, OH 43215
1-800-686-1578; 1-614-644-2658
TTY/TDD: 1-614-644-3745
www.insurance.ohio.gov

OKLAHOMA

**Senior Health Insurance Counseling
Program SHIP Oklahoma Insurance
Department**

2401 N.W. 23rd, Suite 28
Oklahoma City, OK 73107
1-800-763-2828; 1-405-521-6628
TTY/TDD: 711
www.ok.gov/triton

Section

1. State Health Insurance Assistance (SHIP) (con't)

OREGON

Senior Health Insurance Benefits Assistance Program

250 Church Street SE, Suite 200
Salem, OR 97301-3921
1-800-722-4134; 1-503-378-2014
TTY/TDD: 1-800-735-2900
<http://oregonshiba.org>

PENNSYLVANIA

Department of Public Welfare of Pennsylvania

2601 Market Place Street, Suite 320
Harrisburg, PA 17110
1-877-346-6180; 1-717-671-5425
TTY/TDD: 711
www.dpw.state.pa.us

RHODE ISLAND

The Point

35 Howard Avenue
Cranston, RI 02921
1-401-462-4444
TTY/TDD: 1-401-462-4445
<http://adrc.ohhs.ri.gov>

SOUTH CAROLINA

South Carolina's Lieutenant Governor's Office of Aging

1301 Gervais Street, Suite 200
Columbia, SC 29201
1-800-868-9095; 1-803-734-9900
TTY/TDD: 711
www.aging.sc.gov

SOUTH DAKOTA

Senior Health Information & Insurance Education SHINE South Dakota Department of Social Services

700 Governors Drive
Pierre, SD 57501-2291
1-800-536-8197
TTY/TDD: 711

TENNESSEE

TN Commission on Aging and Disability SHIP TN Commission on Aging and Disability

500 Deaderick Street, Suite 825
Nashville, TN 37243-0860
1-877-801-0044; 1-615-741-2056
TTY/TDD: 1-615-532-3893
www.state.tn.us

TEXAS

Health Information Counseling and Advocacy Program Texas Department of Aging and Disability Services

P.O. Box 14200
Midland, TX 79711-4200
1-800-252-8263
TTY/TDD: 1-512-424-6597
www.hhsc.state.tx.us

UTAH

Senior Health Insurance Information Program

120 North 200 West, Room 325
Salt Lake City, UT 84103
1-800-541-7735; 1-801-538-3910
TTY/TDD: 711
www.hsdaas.utah.gov

Section

1. State Health Insurance Assistance (SHIP) (con't)

VERMONT

Vermont State Health Insurance Assistance Program

481 Summer Street, Suite 101
St. Johnsbury, VT 05819
1-800-642-5119; 1-802-748-5182
TTY/TDD: 711
www.medicarehelpvt.net

VIRGINIA

Virginia Department for the Aging

1610 Forest Avenue, Suite 100
Richmond, VA 23229
1-800-552-3402; 1-804-662-9333
TTY/TDD: 711
www.vda.virginia.gov

Virginia Insurance Counseling and Assistance Program Commonwealth of Virginia Department for the Aging

1610 Forest Avenue, Suite 100
Richmond, VA 23229-5009
1-800-552-3402
TTY/TDD: 1-800-552-3402

WASHINGTON

Statewide Health Insurance Benefits Advisors

P.O. Box 40256
Olympia, WA 98504-0256
1-800-562-6900; 1-360-586-2018
TTY/TDD: 1-360-586-0241
www.insurance.wa.gov

WEST VIRGINIA

West Virginia State Health Insurance Assistance Program

1900 Kanawha Blvd. East
Town Center Mall, 3rd Level
Charleston, WV 25305
1-877-987-4463; 1-304-558-3317
TTY/TDD: 711
www.wvship.org

WISCONSIN

Wisconsin Department of Health and Family Services

P.O. Box 7850, 1 W. Wilson St., Rm. 618
Madison, WI 53707-7850
1-800-242-1060
TTY/TDD: 1-888-701-1255, press 1

Wisconsin SHIP

1 West Wilson Street
Madison, WI 53703
1-800-242-1060; 1-608-266-1865
TTY/TDD: 1-608-267-7371
www.dhs.wisconsin.gov/aging/SHIP.htm

WYOMING

Wyoming State Health Insurance Information Program (WSHIIP)

P.O. Box BD
Riverton, WY 82501
1-800-856-4398; 1-307-856-6880
TTY/TDD: 711
www.wyomingseniors.com/WSHIIP.htm

or

106 East 6th Avenue
Cheyenne, WY 82002
1-800-856-4398
TTY/TDD: 711

Section

2. Quality Improvement Organizations (QIO)

ALABAMA

Alabama Quality Assurance Foundation

Two Perimeter Park Drive, Suite 200
West Birmingham, AL 35243-2337

1-205-970-1600

TTY/TDD: 711

Fax: 1-205-970-1600

www.aqaf.com

ALASKA

Mountain-Pacific Quality Health

4241 B Street, Suite 1-303
Anchorage, AK 99503

1-877-561-3202, 1-907-561-3202

TTY/TDD: 711

Fax: 1-907-561-3204

www.mpqhf.com

ARIZONA

Health Services Advisory Group

1600 East Northern Ave., Suite 100
Phoenix, AZ 85020

1-602-264-6382

TTY/TDD: 711

Fax: 1-602-241-0757

www.hsag.com

ARKANSAS

Arkansas Foundation for Medical Care

401 West Capitol
Little Rock, AR 72201

1-501-212-8600

TTY/TDD: 711

Fax: 1-501-244-2101

www.afmc.org

CALIFORNIA

Lumetra

One Sansome Street
San Francisco, CA 94104

1-800-841-1602, 1-415-677-2000

TTY/TDD: 711

Fax: 1-415-677-2195

www.lumetra.com

COLORADO

Colorado Foundation for Medical Care

23 Inverness Way East, Suite 100
Englewood, CO 80112-5708

1-303-695-3300

TTY/TDD: 711

Fax: 1-303-695-3343

www.cfmc.org

CONNECTICUT

Qualidigm

100 Roscommon Drive
Middletown, CT 06457

1-860-632-2008

TTY/TDD: 711

Fax: 1-860-613-3698

www.qualidigm.org

DELAWARE

Quality Insights of Delaware

Baynard Building, Suite 100
3411 Silverside Road
Wilmington, DE 19810-4812

1-302-478-3600

TTY/TDD: 711

Fax: 1-302-478-3873

www.qide.org/de/

Section

2. Quality Improvement Organizations (QIO) (con't)

FLORIDA

Florida Medical Quality Assurance, Inc.

5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609-1822

1-813-354-9111

TTY/TDD: 711

www.fmqai.com

GEORGIA

Georgia Medical Care Foundation

1455 Lincoln Parkway, Suite 1-800
Atlanta, GA 30346

1-800-979-7217

TTY/TDD: 711

www.gmcf.org

HAWAII

Mountain-Pacific Quality Health

1360 South Beretania, Suite 1-501
Honolulu, HI 96814

1-800-524-6550, 1-808-545-2550

TTY/TDD: 711

Fax: 1-808-440-6030

www.mpqhf.org

ILLINOIS

Illinois Foundation for Quality Health Care

2625 Butterfield Road, Suite 102E
Oak Brook, IL 60523-4425

1-800-386-6431, 1-630-571-5540

TTY/TDD: 711

Fax: 1-630-571-5611

www.ifqhc.org

INDIANA

Qualis Health

720 Park Boulevard, #120
Boise, ID 83712

1-800-488-1118, 1-208-343-4617

TTY/TDD: 711

Fax: 1-208-343-4705

www.qualishealth.org/qi/

Health Care Excel, Inc

2629 Waterfront Parkway East Drive
Indianapolis, IN 46214

1-800-288-1499, 1-317-347-4500

TTY/TDD: 1-800-648-6057

Fax: 1-317-347-4545

www.hce.org

IOWA

Iowa Foundation for Medical Care

1779 West Lakes Parkway
West Des Moines, IA 50266

1-800-383-2856, 1-515-223-2900

TTY/TDD: 711

Fax: 1-515-222-2407

www.ifmc.org

KANSAS

Kansas Foundation for Medical Care

2947 SW Wanamaker Drive
Topeka, KS 66614-4193

1-800-432-0407, 1-785-273-2552

TTY/TDD: 711

www.kfmc.org

Section

2. Quality Improvement Organizations (QIO) (con't)

Kansas Foundation for Medical Care

2947 SW Wanamaker Drive
Topeka, KS 66614-4193
1-800-432-0407, 1-785-273-2552
TTY/TDD: 711
Fax: 1-785-273-5130
www.kfmc.org

KENTUCKY

Health Care Excel Incorporated

1941 Bishop Lane, Suite 400
Louisville, KY 40218
1-800-288-1499, 1-502-454-5112
TTY/TDD: 711
Fax: 1-502-454-5113
www.hce.org

LOUISIANA

Louisiana Health Care Review

8591 United Plaza Blvd, Suite 270
Baton Rouge, LA 70809
1-800-433-4958, 1-225-926-6353
TTY/TDD: 711
Fax: 1-225-923-0957
www.lhcr.org

MARYLAND

Delmarva Foundation for Medical Care

9240 Centreville Road
Easton, MD 21601
1-800-999-3362, 1-410-822-0697
TTY/TDD: 711
www.mdqio.org

MASSACHUSETTS

MassPRO

245 Winter Street
Waltham, MA 02451-1231
1-800-252-5533, 1-781-890-0011
TTY/TDD: 711
Fax: 1-781-487-0083
www.masspro.org

MICHIGAN

Michigan Peer Review Organization

22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335-2611
1-800-365-5899, 1-248-465-7300
TTY/TDD: 711
Fax: 1-248-465-7428
www.mpro.org

MINNESOTA

Stratis Health

2901 Metro Drive, Suite 400
Bloomington, MN 55425-1525
1-877-787-2847, 1-952-854-3306
TTY/TDD: 1-800-627-3529
Fax: 1-952-853-8503
www.stratishealth.org

MISSISSIPPI

Information and Quality Healthcare of Mississippi

385B Highland Colony Pkwy., Suite 504
Ridgeland, MS 39157
1-800-844-0600, 1-601-957-1575
TTY/TDD: 711
Fax: 1-601-956-1713
www.iqh.org

Section

2. Quality Improvement Organizations (QIO) (con't)

MISSOURI

Primaris

200 North Keene Street
Columbia, MO 65210
1-800-735-6776, 1-573-817-8300
TTY/TDD: 1-800-735-2966
Fax: 1-573-817-8330
www.primaris.org

MONTANA

Mountain-Pacific Quality Health Foundation

3404 Cooney Drive
Helena, MT 59602
1-800-497-8232, 1-406-443-4020
TTY/TDD: 711
Fax: 1-406-443-4585
www.mpqhf.org

NEBRASKA

Cimro of Nebraska

1230 O Street, Suite 120
Lincoln, NE 68508
1-800-458-4262, 1-402-476-1399
TTY/TDD: 711
Fax: 1-402-476-1335
www.cimronebraska.org

NEVADA

Health Insight

6830 W. Oquendo Road, Suite 102
Las Vegas, NV 89118
1-800-748-6773, 1-702-385-9933
TTY/TDD: 711
Fax: 1-702-385-4586
www.healthinsight.org

NEW HAMPSHIRE

Northeast Health Care Quality Foundation

15 Old Rollinsford Road, Suite 1-302
Dover, NH 03820-2830
1-800-772-0151, 1-603-749-1641
TTY/TDD: 711
Fax: 1-603-749-1195
www.nhcqf.org

NEW JERSEY

Healthcare Quality Strategies Inc.

557 Cranbury Road, Suite 21
East Brunswick, NJ 08816-4026
1-800-624-4557, 1-732-238-5570
TTY/TDD: 711
www.pronj.org

NEW MEXICO

New Mexico Medical Review Association

5801 Osuna Road NE, Suite 200
Albuquerque, NM 87109
1-800-663-6351, 1-505-998-9898
TTY/TDD: 711
www.nmmra.org

NEW YORK

Island Peer Review Organization

1979 Marcus Avenue, 1st Floor
Lake Success, NY 11042-1002
1-800-331-7767
TTY/TDD: 1-516-326-6182
Fax: 1-516-328-2310
www.ipro.org

Section

2. Quality Improvement Organizations (QIO) (con't)

NORTH CAROLINA

Medical Review of North Carolina, Inc.

100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598

1-800-682-2650, 1-919-380-9860

TTY/TDD: 1-800-735-2962

Fax: 1-919-380-7637

www.thecarolinascenter.org

NORTH DAKOTA

North Dakota Health Care Review

800 31st Ave SW,
Minot, ND 58701

1-800-472-2902, 1-701-852-4231

TTY/TDD: 711

Fax: 1-701-838-6009

www.ndhcri.org

OHIO

KePRO Rock Run Center

5700 Lombardo Center Drive
Rock Run Center, Suite 100
Seven Hills, OH 44131

1-216-447-9604, 1-800-750-0750

TTY/TDD: 1-800-325-0778

Fax: 1-216-447-7925

www.ohiokepro.com

OKLAHOMA

Oklahoma Foundation for Medical Quality

14000 Quail Springs Parkway, Suite 400
Oklahoma City, OK 73134-2600

1-800-522-3414, 1-405-840-2891

TTY/TDD: 711

Fax: 1-405-858-9097

www.ofmq.com

OREGON

Acumentra Health

2020 SW Fourth Avenue, Suite 520
Portland, OR 97201

1-800-344-4354, 1-503-279-0100

TTY/TDD: 711

Fax: 1-503-279-0190

www.acumentra.org

PENNSYLVANIA

Quality Insights of Pennsylvania

2601 Market Place Street, Suite 320
Harrisburg, PA 17110

1-877-346-6180, 1-717-671-5425

TTY/TDD: 711

www.qipa.org

RHODE ISLAND

Quality Partners of Rhode Island

235 Promenade Street, Suite 500, Box 18
Providence, RI 02908

1-800-662-5028, 1-401-528-3200

TTY/TDD: 711

Fax: 1-401-528-3210

www.riqualitypartners.org

SOUTH CAROLINA

The Carolinas Center for Medical Excellence

246 Stoneridge Drive, Suite 200
Columbia, SC 29210

1-800-922-3089, 1-803-251-2215

TTY/TDD: 1-800-735-8583

Fax: 1-803-255-0897

www.thecarolinascenter.org

Section

2. Quality Improvement Organizations (QIO) (con't)

SOUTH DAKOTA

South Dakota Foundation for Medical Care

2600 West 49th Street, Suite 300, P.O. Box
7406

Sioux Falls, SD 57117-7406

1-605-336-3505

TTY/TDD: 711

TENNESSEE

Qsource

3175 Lenox Park Blvd., Suite 309
Memphis, TN 38115

1-800-528-2655, 1-901-682-0381

TTY/TDD: 711

www.qsource.org

TEXAS

TMF Health Quality Institute

Suite 300 5918 West Courtyard Drive,
Bridgepoint I

Austin, TX 78730-5036

1-800-725-9216, 1-512-329-6610

TTY/TDD: 711

Fax: 1-512-327-7159

www.tmf.org

UTAH

HealthInsight

348 East 4500 South, Suite 300
Salt Lake City, UT 84107

1-801-892-0155

TTY/TDD: 711

Fax: 1-801-892-0160

www.healthinsight.org

VIRGINIA

Virginia Health Quality Center (Richmond)

9830 Mayland Drive, Suite J
Richmond, VA 23233

1-866-263-8402, 1-804-289-5320

TTY/TDD: 1-877-486-2048

Fax: 1-804-289-5324

www.vhqc.org

Virginia Health Quality Center (Glen Allen)

4510 Cox Road, Suite 400
Glen Allen, VA 23060

1-804-289-5320

TTY/TDD: 711

www.vhqc.org

WASHINGTON

Mountain-Pacific Quality Health

10700 Meridian N., Suite 100
Seattle, WA 98133

1-800-949-7536, 1-206-364-9700

TTY/TDD: 711

www.qualishealth.org

WEST VIRGINIA

West Virginia Medical Institute, Inc. Quality Insights

3001 Chesterfield Place
Charleston, WV 25304

1-800-642-8686, 1-304-346-9864

TTY/TDD: 711

www.wvmi.org

Section

2. Quality Improvement Organizations (QIO) (con't)

WISCONSIN

MetaStar Inc.

2909 Landmark Place
Madison, WI 53713

1-800-362-2320, 1-608-274-1940

TTY/TDD: 711

Fax: 1-608-274-5008

www.metastar.com

WYOMING

Mountain-Pacific Quality Health

2206 Dell Range Blvd., Suite G
Cheyenne, WY 82009

1-877-810-6248, 1-307-637-8162

TTY/TDD: 711

Fax: 1-307-637-8163

www.mpqhf.com

or

P.O. Box 2242, 409 South 4th
Glenrock, WY 82637

Section

3. State Medicaid Offices

ALABAMA

Medicaid Agency of Alabama

501 Dexter Avenue, P.O. Box 5624
Montgomery, AL 36103

1-800-362-1504, 1-334-206-5175

TTY/TDD: 711

www.medicaid.state.al.us

ALASKA

Alaska Department of Health & Social Services

350 Main Street Room 229, P.O. Box 110601
Juneau, AK 99811-0601

1-800-780-9972, 1-800-770-5650

TTY/TDD: 711

<http://health.hss.state.ak.us>

ARIZONA

Arizona Department of Health Services

801 E. Jefferson
Phoenix, AZ 85034

1-800-654-8713, 1-602-417-4000

TTY/TDD: 1-602-417-4191

<http://www.azdhs.gov>

ARKANSAS

Department of Human Services of Arkansas

P.O. Box 1437, Donaghey Plaza, Slot 1100
Little Rock, AR 72203

1-800-482-5431

TTY/TDD: 1-501-682-6789

www.arkansas.gov/dhs/

CALIFORNIA

California Department of Health Services Medi-Cal Policy Division

P.O. Box 997413
Sacramento, CA 95899-7413

1-916-636-1980

TTY/TDD: 711

www.dhs.ca.gov

California Department of Health Services

1500 Capitol Avenue, Suite 714063
Sacramento, CA 95899

1-916-552-9200

TTY/TDD: 711

COLORADO

Colorado Department of Healthcare Policy and Financing

1570 Grant Street
Denver, CO 80203

1-303-866-2993, 1-303-866-3883

TTY/TDD: 1-303-866-3883

www.colorado.gov

CONNECTICUT

Department of Social Services of Connecticut

25 Sigourney Street
Hartford, CT 06106

1-800-842-1508, 1-860-509-8000

TTY/TDD: 711

www.ct.gov/dss/

Section

3. State Medicaid Offices (con't)

DELAWARE

Delaware Health and Social Services

1901 N. DuPont Highway, P.O. Box 906,
Lewis Bldg.
New Castle, DE 19720
1-800-372-2022, 1-302-255-9040
TTY/TDD: 711
www.dhss.delaware.gov

DISTRICT OF COLUMBIA

DC Healthy Family

825 North Capitol Street NE, 5th Floor
Washington, DC 20002
1-888-557-1116
TTY/TDD: 1-202-639-4041
<http://app.doh.dc.gov/>

FLORIDA

Florida Department of Health

4052 Bald Cypress Way, Bin #B06
Tallahassee, FL 32399-1734
1-850-245-4494
TTY/TDD: 711
www.doh.state.fl.us

GEORGIA

Georgia Department of Community Health

2 Peachtree Street
NW Atlanta, GA 30303
1-866-322-4260
TTY/TDD: 711
<http://dch.georgia.gov>

HAWAII

Department of Human Services of Hawaii

P.O. Box 339
Honolulu, HI 96809
1-808-587-3521
TTY/TDD: 1-808-692-7182
www.hawaii.gov/dhs/

IDAHO

Idaho Department of Health and Welfare – Division of Medicaid

3232 Elder
Boise, ID 83705
1-877-200-5441
TTY/TDD: 711
www.healthandwelfare.idaho.gov

ILLINOIS

Illinois Department of Healthcare and Family Services

201 South Grand Avenue East
Springfield, IL 62763
1-217-782-1200, 1-800-782-71-860,
1-800-545-2200 (Spanish)
TTY/TDD: 711
www.hfs.illinois.gov

INDIANA

Family and Social Services Administration of Indiana

402 W. Washington St., P.O. Box 7083
Indianapolis, IN 46207
1-888-673-0002, 1-317-233-4454
TTY/TDD: 1-800-743-3333
www.in.gov/fssa/

Section

3. State Medicaid Offices (con't)

IOWA

Iowa Department of Human Services

Hoover State Office Building
1305 E. Walnut Street
Des Moines, IA 50319
1-800-338-8366, 1-515-281-4115
TTY/TDD: 711
www.dhs.state.ia.us

KANSAS

Department of Social and Rehabilitation Services of Kansas

915 SW Harrison, DSOB 9th Floor
Topeka, KS 66612
1-800-766-9012, 1-785-274-4200
TTY/TDD: 1-785-296-1491
www.srskansas.org

Kansas Department on Aging New England Building

503 S. Kansas Ave.
Topeka, KS 66603-3404
1-800-432-3535
TTY/TDD: 1-785-291-3167
www.agingkansas.org

KENTUCKY

Cabinet for Health Services of Kentucky

275 East Main
Frankfort, KY 40621
1-800-635-2570, 1-502-564-4321
TTY/TDD: 1-800-627-4702
www.chfs.ky.gov

LOUISIANA

Louisiana Department of Health and Hospital

P.O. Box 629, 628 N. 4th Street
Baton Rouge, LA 70821-9278
1-888-342-6207, 1-225-342-9500
TTY/TDD: 1-225-216-7387
www.dhh.louisiana.gov

MAINE

Maine Department of Health and Human Services

11 State House Station
Augusta, ME 04333
1-800-977-6740, 1-207-287-9202
TTY/TDD: 1-800-606-0215
www.maine.gov/dhhs/

MARYLAND

Maryland Department of Health and Mental Hygiene

201 West Preston Street, P.O. Box 17259
Baltimore, MD 21203-7259
1-800-492-5231, 1-410-767-5800
TTY/TDD: 711
www.dhmh.state.md.us

MASSACHUSETTS

Massachusetts Office of Medicaid

One Ashburton Place, 11th Floor
Boston, MA 02108
1-800-325-5231, 1-617-573-1770
TTY/TDD: 1-800-530-7570
www.mass.gov

Section

3. State Medicaid Offices (con't)

MICHIGAN

Michigan Department of Community Health

320 South Walnut Street, Sixth Floor
Lewis Cass Building
Lansing, MI 48913

1-800-642-3195, 1-517-373-3740

TTY/TDD: 1-517-373-3573

www.michigan.gov/mdch

MINNESOTA

Minnesota Department of Human Services

DHHS Metro, 85 East Seventh Place, Ste. 105
St. Paul, MN 55101

1-800-657-3739, 1-651-431-2000

TTY/TDD: 1-800-627-3529

www.dhs.state.mn.us

MISSISSIPPI

Mississippi Division of Medicaid

550 High Street Suite 1000, Sillers Building
Jackson, MS 39201-1399

1-800-421-2408, 1-601-359-6050

TTY/TDD: 711

www.medicaid.ms.gov

MISSOURI

Missouri Medicaid Department of Social Services Division of Medical Services

P.O. Box 6500, 615 Howerton Ct
Jefferson City, MO 65102

1-800-392-2161, 1-800-735-2466

TTY/TDD: 1-800-735-2966

MONTANA

Montana Department of Public Health and Human Services Division of Child and Adult Health Resources

111 North Sanders, NW P.O. Box 4210
Helena, MT 59620

1-800-362-8312, 1-406-444-4540

TTY/TDD: 1-406-444-2590

www.dphhs.mt.gov

NEBRASKA

Nebraska Department of Health and Human Services System

P.O. Box 95044
Lincoln, NE 68509-5044

1-800-430-3244, 1-402-471-3121

TTY/TDD: 1-402-471-9570

www.hhs.state.ne.us

NEVADA

Nevada Department of Human Resources, Aging Division

3416 Goni Road, Suite D #132
Carson City, NV 89701

1-800-992-0900, 1-775-684-0800

TTY/TDD: 711

www.nvaging.net

NEW HAMPSHIRE

New Hampshire Department of Health and Human Services

129 Pleasant Street
Concord, NH 03301-3857

1-800-852-3345 x5254, 1-603-271-5254

TTY/TDD: 1-800-735-2964

www.dhhs.state.nh.us

Section

3. State Medicaid Offices (con't)

NEW JERSEY

**Department of Human Services
of New Jersey**

P.O. Box 712, Quakerbridge Plaza
Trenton, NJ 08625-0712

1-800-356-1561, 1-609-588-2600

TTY/TDD: 711

www.nj.gov

NEW MEXICO

**Department of Human Services
of New Mexico**

P.O. Box 2348
Santa Fe, NM 87504-2348

1-888-997-2583, 1-505-827-3184

TTY/TDD: 711

www.hsd.state.nm.us

NEW YORK

**Office of Medicaid Management,
Corning Tower**

Empire State Plaza
Albany, NY 12223

1-800-541-2831, 1-518-486-9057

TTY/TDD: 711

www.health.state.ny.us/health_care/medicaid

NORTH CAROLINA

**North Carolina Department of Health
and Human Services**

2012 Mail Service Center
Raleigh, NC 27699-2012

1-800-662-7030, 1-919-733-4534

TTY/TDD: 1-877-733-4851

www.dhhs.state.nc.us/dma/medicaid/

NORTH DAKOTA

**Department of Human Services
of North Dakota- Medical Services**

600 E. Boulevard Avenue, Dept 325
Bismarck, ND 58505-0250

1-800-472-2622, 1-701-328-2310

TTY/TDD: 1-701-328-3480

www.nd.gov/dhs/

OHIO

**Department of Job and Family Services
of Ohio Health Plans**

50 W Town Street
Columbus, OH 43215

1-800-324-8680, 1-614-644-0140

TTY/TDD: 1-800-292-3572

<http://jfs.ohio.gov/ohp/>

OKLAHOMA

Oklahoma State Department of Health

1000 N.E. 10th Street
Oklahoma City, OK 73117

1-800-522-0310, 1-405-522-5818

TTY/TDD: 1-405-271-6067

www.okhca.org

OREGON

Division of Medical Assistance Programs

Administrative Office, 500 Summer Street NE
Salem, OR 97301-1079

1-800-527-5772, 1-503-945-5772

TTY/TDD: 1-800-375-2863

www.oregon.gov/DHS/healthplan/

Section

3. State Medicaid Offices (con't)

PENNSYLVANIA

Department of Public Welfare of Pennsylvania

P.O. Box 2675, Health and Welfare Bldg.
Room 515
Harrisburg, PA 17105
1-800-692-7462, 1-877-724-3258
TTY/TDD: 1-717-705-7103
www.dpw.state.pa.us

RHODE ISLAND

Rhode Island Department of Human Services

600 New London Avenue, Forand Building
Div. of Health Care Quality, Fin.
and Purchasing
Cranston, RI 02920
1-800-984-8989, 1-401-462-5300
TTY/TDD: 1-401-462-3363
www.dhs.ri.gov

SOUTH CAROLINA

South Carolina Department of Health and Human Services

P.O. Box 8206
Columbia, SC 29202
1-888-549-0820, 1-803-898-2500
TTY/TDD: 711
www.scdhhs.gov

SOUTH DAKOTA

Department of Social Services of South Dakota

700 Governors Drive, Richard F. Kneip Bldg
Pierre, SD 57501
1-800-452-7691, 1-605-773-3495
TTY/TDD: 711

TENNESSEE

Bureau of Tennessee Care

310 Great Circle Rd.
Nashville, TN 37243
1-866-311-4287, 1-615-741-3111
TTY/TDD: 711
www.tn.gov/tenncare/

TEXAS

Health and Human Services Commission of Texas

4900 N. Lamar Boulevard, 4th Floor
Austin, TX 78701
1-800-252-6758, 1-512-458-7111
TTY/TDD: 711
www.hhsc.state.tx.us

UTAH

Utah Department of Health Division of Health Care Financing

P.O. Box 143106
Salt Lake City, UT 84114
1-800-662-9651, 1-801-538-6155
TTY/TDD: 711
www.health.utah.gov/medicaid

VERMONT

Agency of Human Services of Vermont

103 South Main Street, Osgood 3
Waterbury, VT 05676
1-800-250-8427, 1-802-241-1282
TTY/TDD: 711
www.dcf.vermont.gov

Section

3. State Medicaid Offices (con't)

VIRGINIA

Department Of Medical Assistance Services

600 East Broad Street Suite 1300
Richmond, VA 23219

1-804-786-7933, 1-804-786-7933

TTY/TDD: 1-800-343-0634

www.dmas.virginia.gov

WASHINGTON

Department of Social and Health Services of Washington

DSHS, PO Box 45130
Olympia, WA 98504-5130

1-800-737-0617

TTY/TDD: 711

www.dshs.wa.gov

WEST VIRGINIA

West Virginia Department of Health and Human Resources

350 Capital Street, Room 251
Office of Administration
Charleston, WV 25301-3709

1-304-558-1700, 1-304-558-1703

TTY/TDD: 711

<http://www.wvdhhr.org/bms/>

WISCONSIN

Wisconsin Department of Health and Family Services

1 West Wilson Street
Madison, WI 53703

1-800-362-3002, 1-608-266-1865

TTY/TDD: 1-608-267-7371

<http://dhs.wisconsin.gov/medicaid/>

WYOMING

Wyoming Department of Health

147 Hathaway Building
Cheyenne, WY 82002

1-307-777-7531, 1-307-777-7656

TTY/TDD: 1-307-777-5648

Wyoming Department of Health, Equality Care (Medicaid)

401 Hathaway Building
Cheyenne, WY 82002

1-866-571-0944, 1-307-777-7656

TTY/TDD: 1-307-777-5648

<http://wdh.state.wy.us/healthcarefin/equalitycare>

Section

4. State Medicare Offices

Medicare

1-800-MEDICARE

(1-800-633-4227)

TTY/TDD: 1-877-486-2048

Seven days a week, 24 hours a day

www.medicare.gov

CALIFORNIA

Office of the Regional Administrator
90 - 7th Street, Suite 5-300
San Francisco, CA 94103-6706

COLORADO

Office of the Regional Administrator
1600 Broadway, Suite 700
Denver, CO 80202-4367

GEORGIA

Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

ILLINOIS

Office of the Regional Administrator
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

MASSACHUSETTS

Office of the Regional Administrator
JFK Federal Building, Suite 2325
Boston, MA 02203-0003

MISSOURI

Office of the Regional Administrator
601 E. 12th Street, Suite 235
Kansas City, MO 64106

NEW YORK

Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063

PENNSYLVANIA

Suite 216, The Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106

TEXAS

Office of the Regional Administrator
1301 Young Street, Suite 714
Dallas, TX 75202

WASHINGTON

Office of the Regional Administrator
2201 6th Avenue, Suite 801
Seattle, WA 98121

5. State Pharmacy Assistance Program (SPAP)

ALABAMA

SenioRx/Wellness

770 Washington Avenue RSA Plaza
Suite 470
Montgomery, AL 36130
1-800-243-5463
TTY/TDD: 711
www.adss.state.al.us/seniorx.cfm

ALASKA

Department of Health

240 Main Street, Suite 601
Juneau, AK 99811-0680
1-907-465-3372, 1-866-465-3165
TTY/TDD: 1-907-465-5430

ARIZONA

CoppeRx Card® Prescription Discount Program

1-888-227-8315, 1-800-770-8014
TTY/TDD: 711
www.rxamerica.com/az_discount_info.html

ARKANSAS

Department of Human Services of Arkansas / Non profit prescription assistance prog.

P.O. Box 56248
Little Rock, AR 72215
1-800-950-8233, 1-501-221-3033
TTY/TDD: 711

CALIFORNIA

California Prescription Drug Discount Program for Medicare Recipients Medi-Cal

P.O. Box 997417, MS 4604,
Sacramento, CA 95814
1-916-488-5298, 1-800-434-0222
TTY/TDD: 711
www.dhcs.ca.gov

COLORADO

Colorado Bridging the Gap

4300 Cherry Creek Drive South
Denver, CO 80246
1-303-692-2783, 1-303-692-2783
TTY/TDD: 711
www.cdphe.state.co.us/dc/HIVandSTD/ryanwhite/medicare.html

CONNECTICUT

Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE)

P.O. Box 5011
Hartford, CT 06102
1-800-423-5026
TTY/TDD: 711
www.connpace.com

DELAWARE

Delaware Prescription Assistance Program

P.O. Box 950
New Castle, DE 19720
1-800-996-9969
TTY/TDD: 711
www.state.de.us/dhss/dss/dpap.html

5. State Pharmacy Assistance Program (SPAP) (con't)

DISTRICT OF COLUMBIA

DC Healthcare Alliance

1025 15th Street, N.W.
Washington, DC 20005
1-202-842-2810, 1-866-842-2810
TTY/TDD: 711

FLORIDA

Florida Comprehensive Health Association

820 E. Park Avenue
Tallahassee, FL 32301
1-850-309-1200
TTY/TDD: 711
www.ncsl.org/IssuesResearch/Health/

GEORGIA

Georgia Partnership for Caring Foundation

P.O. Box 450987
Atlanta, GA 31145-0987
1-800-982-4723, 1-678-578-2920
TTY/TDD: 711
www.gacares.org

HAWAII

State Pharmacy Assistance Program

P.O. Box 700220
Kapolei, HI 96709
TTY/TDD: 711

IDAHO

RxIdaho

1-888-477-2669
TTY/TDD: 711
www.rxidaho.org

ILLINOIS

Illinois Cares Rx Illinois Department on Aging

P.O. Box 19021
Springfield, IL 62794
1-800-226-0768
TTY/TDD: 711
www.illinoiscaresrx.com

INDIANA

HoosiersRX

P.O. Box 6224
Indianapolis, IN 46206
1-317-234-1381, 1-866-267-4679
TTY/TDD: 711
www.in.gov/fssa/elderly/hoosierx/

IOWA

Iowa prescription Drug donation program

321 E. 12th Street
Des Moines, IA 50319-0075
1-866-282-5817, 1-515-327-5405
TTY/TDD: 711

5. State Pharmacy Assistance Program (SPAP) (con't)

KANSAS

CommunityRx Kansas

Curtis State Office Building, 1000 SW
Jackson Street, Suite 540
Topeka, KS 66612

1-785-296-1086, 1-866-424-6423

TTY/TDD: 711

www.healthykansas.org

KENTUCKY

Cabinet for Health and Family Services

275 E. Main St.
Frankfort, KY 40621

1-800-372-2973, 1-502-564-5497

TTY/TDD: 1-800-627-4702

www.chfs.ky.gov

MAINE

Maine Low Cost Drugs for the Elderly or Disabled Program Office of Maine Care Services

11 State House Station
Augusta, ME 04333

1-866-796-2463

TTY/TDD: 711

www.mainearepdl.org

MARYLAND

Maryland Senior Prescription Drug Assistance Program

P.O. Box 386
Baltimore, MD 21203

1-800-226-2142

TTY/TDD: 1-800-877-5156

www.marylandspdap.com

MASSACHUSETTS

Massachusetts Prescription Advantage

P.O. Box 15153
Worcester, MA 01615

1-800-243-4636

TTY/TDD: 1-877-610-0241

www.mass.gov

MICHIGAN

MiRx

Capitol View Building, 201 Townsend Street
Lansing, MI 48913

1-866-755-6479, 1-800-375-1406

TTY/TDD: 711

<http://www.mihealth.org/mirx/>

MISSOURI

Missouri Rx Plan

P.O. Box 6500205, Jefferson Street, 14th Floor
Jefferson City, MO 65101

1-800-375-1406

TTY/TDD: 711

www.morx.mo.gov

MONTANA

Big Sky Rx Program

P.O. Box 202915
Helena, MT 59620

1-866-369-1233

TTY/TDD: 711

www.bigskyrx.mt.gov

5. State Pharmacy Assistance Program (SPAP) (con't)

NEBRASKA

State Unit on Aging

P.O. Box 95044, 301 Centennial Mall South
Lincoln, NE 68509-5044

1-800-430-3244, 1-402-471-3121

TTY/TDD: 1-402-471-9570

www.hhs.state.ne.us

NEVADA

Nevada Senior Rx Program

4126 Technology Way, Suite 101
Carson City, NV 89706

1-866-303-6323, 1-775-687-7555

TTY/TDD: 711

<http://dhhs.nv.gov/Sitemap.htm>

NEW HAMPSHIRE

NH Medication Bridge Program

125 Airport Road
Concord, NH 03301

1-800-852-3456, 1-603-225-0900

TTY/TDD: 711

www.healthynh.com

NEW JERSEY

New Jersey Senior Gold Prescription Discount Program

P.O. Box 724
Trenton, NJ 08625

1-800-792-9745

TTY/TDD: 711

www.state.nj.us/health/seniorbenefits/

NEW MEXICO

New Mexico Medbank Program

New Mexico Aging & Long-Term Services
Department, 2550 Cerrillos Road
Santa Fe, NM 87505

1-800-432-2080, 1-505 476-4772

TTY/TDD: 711

www.nmaging.state.nm.us/medbank.html

NEW YORK

Elderly Pharmaceutical Insurance Coverage EPIC

P.O. Box 15018
Albany, NY 12212

1-800-332-3742

TTY/TDD: 1-800-290-9138

www.health.state.ny.us/health_care/epic/

NORTH CAROLINA

Senior Health Insurance Information Program

11 S. Boyan Avenue
Raleigh, NC 27603

1-800-443-9354, 1-919-807-6900

TTY/TDD: 1-919-715-0319

www.ncdoi.com/Consumer/SHIIP/SHIIP.asp

OHIO

Ohio's Best Rx

P.O. Box 408
Twinsburg, OH 44087-0408

1-866-9BESTRX, 1-614-466-9783

TTY/TDD: 1-866-763-9630

www.ohiobestrx.org

5. State Pharmacy Assistance Program (SPAP) (con't)

OKLAHOMA

Rx for Oklahoma

900 North Stiles Avenue
Oklahoma City, OK 73104-3234
1-800-879-6552, 1-405-815-6552
TTY/TDD: 711
www.okcommerce.gov/contacts

OREGON

Oregon Prescription Drug Program

General Services Building
1225 Ferry Street SE
Salem, OR 97301
1-888-411-6737, 1-503-373-1603
TTY/TDD: 711
www.oregon.gov/OHPPR/

PENNSYLVANIA

Pharmaceutical Assistance Contract for the Elderly PACE Program

1st. Health Services, 4000 Crums Mill Road
Suite 301
Harrisburg, PA 17112
1-800-225-7223
TTY/TDD: 711
<http://pacecares.fhsc.com>

RHODE ISLAND

Rhode Island Prescription Assistance for the Elderly (RIPAE)

Attention RIPAE, John O. Pastore Center,
Hazard Building, 74 West Road
Cranston, RI 02920
1-401-462-3000
TTY/TDD: 711
www.dea.state.ri.us/programs/

SOUTH CAROLINA

South Carolina Gap Assistance Pharmacy Program for Seniors (GAPS)

P.O. Box 8206
Columbia, SC 29202
1-888-549-0820
TTY/TDD: 711
www.dhhs.state.sc.us

TENNESSEE

Cover Tennessee

312 Rosa L. Parks Avenue, Suite 2600
Nashville, TN 37243
1-866-268-3786
TTY/TDD: 711
www.covertn.gov

TEXAS

Texas State Pharmacy Assistance Programs

1100 W. 49th St.
Austin, TX 78756
1-800-222-3986, 1-512-458-7150
TTY/TDD: 1-512-458-7162
www.dshs.state.tx.us

UTAH

Utah Medicaid Pharmacy Program

P.O. Box 143102
Salt Lake City, UT 84114
1-801-538-6155, 1-800-662-9651
TTY/TDD: 711

5. State Pharmacy Assistance Program (SPAP) (con't)

VERMONT

Vermont V Pharm

312 Hurricane Lane, Suite 201
Willston, VT 05495

1-800-250-8427

TTY/TDD: 711

www.greenmountaincare.org

VIRGINIA

Department Of Medical Assistance Services

1610 Forest Avenue, Suite 100
Richmond, VA 23229

1-800-552-3402, 1-804-662-9333

TTY/TDD: 711

www.vda.virginia.gov

Virginia Department of Health SPAP Patient services Incorporated

P.O. Box 2448
Richmond, VA 23218-2448

1-800-366-7741

TTY/TDD: 711

WASHINGTON

Washington State Health Insurance Pharmacy Assistance Program

P.O. Box 1090
Great Bend, KS 67530

1-800-877-5187

TTY/TDD: 711

www.wship.org

WEST VIRGINIA

West Virginia Rx Program

1520 Washington Street, East
Charleston, WV 25311

1-877-388-9879

TTY/TDD: 711

www.wvrx.org

WISCONSIN

Wisconsin Senior Care

P.O. Box 6710
Madison, WI 53716

1-800-657-2038

TTY/TDD: 711

www.dhfs.state.wi.us/seniorcare/

WYOMING

The Wyoming Prescription Drug Assistance Program (PDAP)

6101 Yellowstone, Suite 259B
Cheyenne, WY 82002

1-800-438-5785, 1-307-777-6923

TTY/TDD: 711

<http://wdh.state.wy.us/healthcarefin/pharmacy/>

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia)

ALABAMA

Civil Rights Civil Rights/EEO

50 Ripley Street
Montgomery, AL 36130
1-800-548-2547, 1-334-242-1550
TTY/TDD: 1-334-242-0196
www.usccr.gov/pubs/crd/stateloc/al.htm

ALASKA

Alaska State Commission for Human Rights

800 A Street, Suite 204
Anchorage, AK 99105-3669
1-800-478-4692, 1-907-274-4692
TTY/TDD: 1-800-478-3177
www.gov.state.ak.us/aschr/aschr.htm

ARIZONA

ARIZONA CIVIL RIGHTS DIVISION Office of the Arizona Attorney General

1275 W. Washington Street
Phoenix, AZ 85007-2926
1-602-542-5263
TTY/TDD: 1-602-542-5002
www.attorney_general.state.az.us

CALIFORNIA

Office for Civil Rights San Francisco Office

U.S. Department of Education Old Federal
Building, 50 United Nations Plaza,
Room 239
San Francisco, CA 94102-4912
1-415-556-4275
TTY/TDD: 711

Public Inquiry Unit

P.O. Box 944255
Sacramento, CA 94244-2550
1-916-322-3360
TTY/TDD: 711

COLORADO

Colorado Civil Rights Division

1560 Broadway, Suite 1050
Denver, CO 80202
1-303-894-2997, 1-800-262-4845
TTY/TDD: 711
www.dora.state.co.us/civil-rights

CONNECTICUT

Commission on Human Rights and Opportunities

21 Grand St.
Hartford, CT 06106
1-860-541-3400, 1-800-477-5737
TTY/TDD: 711
www.state.ct.us/chro

DELAWARE

Delaware Human Relations Division

820 French St., 4th Floor
Wilmington, DE 19801
1-302-577-5050
TTY/TDD: 711
www.state.de.us/sos/human.htm

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia) (con't)

DISTRICT OF COLUMBIA

No state CRC agency listed? Contact Washington DC Office.

U.S. Commission on Civil Rights
624 Ninth Street NW
Washington, DC 20425
1-202-376-8128
TTY/TDD: 711

District of Columbia Office of Human Rights

441 4th St. NW Suite 970N
Washington, DC 20001
1-202-727-3900, 1-202-724-3786
TTY/TDD: 711
ohr.dc.gov/

Office for Civil Rights: U.S. Department of Health and Human Services

200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-303-844-2024
TTY/TDD: 1-303-844-3439
www.hhs.gov/ocr/office/

FLORIDA

Florida Commission on Human Relations

Building F Suite 240, 325 John Knox Rd.
Tallahassee, FL 32399-4149
1-850-488-7082, 1-800-342-8170
TTY/TDD: 711
fchr.state.fl.us/

GEORGIA

Georgia Commission on Equal Opportunity

Suite 1002 - West Tower
2 Martin Luther King Jr. Drive SE
Atlanta, GA 30334
1-617-565-1340, 1-800-473-OPEN (in Georgia), Fax: 404-656-4399
TTY/TDD: 1-617-565-1343

Office for Civil Rights, U.S. Department of Health and Human Services

Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
1-800-368-1019, 1-404-562-7886
TTY/TDD: 1-404-331-2867
www.hhs.gov/ocr/office/

HAWAII

Hawaii Civil Rights Commission

830 Punchbowl St. Room 411
Honolulu, HI 96813
1-808-586-8636
TTY/TDD: 711
www.state.hi.us/hcrc

ILLINOIS

Illinois Dept. of Human Rights

100 W Randolph St., Suite 10-100
Chicago, IL 60601
1-312-814-6200, 1-800-662-3942
TTY/TDD: 711
www.state.il.us/dhr

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia) (con't)

Office for Civil Rights, U.S. Department of Health and Human Services

233 N. Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, 1-312-886-2359
TTY/TDD: 1-312-353-5693
www.hhs.gov/ocr/office/

IDAHO

Idaho Human Rights Commission

1109 Main St. 4th Floor, P.O. Box 83720
Boise, ID 83720
1-208-334-2873
TTY/TDD: 711
www.state.id.us/ihr

KANSAS

Kansas Human Rights Commission

900 SW Jackson St., Suite 851-S
Topeka, KS 66612-1258
1-785-296-3206
TTY/TDD: 711
www.ink.org/public/khrc

LOUISIANA

Louisiana Commission on Human Rights

1001 N. 23rd St., Suite 262
Baton Rouge, LA 70802
1-225-342-6969, 1-225-342-2063
TTY/TDD: 1-888-248-0859
www.gov.state.la.us/depts/lchr.htm

MAINE

Maine Human Rights Commission

51 State House Station
Augusta, ME 04333-0051
1-207-624-6050
TTY/TDD: 1-888-577-6690
www.state.me.us/mhrc/

MARYLAND

Maryland Human Rights Commission

6 St. Paul St. 9th Floor
Baltimore, MD 21202-1631
1-800-637-6247, 1-410-767-8600
TTY/TDD: 711
www.mchr.state.md.us

MASSACHUSETTS

U.S. Department of Health and Human Services

Government Center, J.F. Kennedy Federal Building - Room 1875
Boston, MA 02203
1-800-368-1019, 1-617-565-1340
TTY/TDD: 1-617-565-1343
www.hhs.gov/ocr/office/

Office for Civil Rights, U.S. Department of Health and Human Services

Government Center, J.F. Kennedy Federal Building - Room 1875
Boston, MA 02203
1-800-368-1019, 1-617-565-1340
TTY/TDD: 1-617-565-1343
www.hhs.gov/ocr/office/

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia) (con't)

MICHIGAN

Michigan Dept. of Civil Rights

Victor Bldg. Suite 700, 201 N Washington
Square
Lansing, MI 48933

1-517-335-3165, 1-312-886-2359

TTY/TDD: 1-312-353-5693

www.mdcr.state.mi.us/mdcr/

MISSOURI

Office for Civil Rights, U.S. Department of Health and Human Services

601 East 12th Street, Room 248
Kansas City, MO 64106

1-800-368-1019, 1-816-426-7277

TTY/TDD: 1-816-426-7065

www.hhs.gov/ocr/office/

Missouri Commission on Human Rights Dept. of Labor and Industrial Relations

3315 W. Truman Blvd., Room 212
P.O. Box 1129
Jefferson City, MO 65102-1129

1-877-781-4236, 1-573-751-4091

TTY/TDD: 1-800-735-2966

www.dolir.mo.gov

MONTANA

Dept. of Labor and Industry Human Rights Commission

P.O. Box 1728
Helena, MT 59620

1-800-542-0807, 1-406-444-2884

TTY/TDD: 1-406-444-9696

www.erd.dli.mt.gov

NEBRASKA

The Nebraska Equal Opportunity Commission

301 Centennial Mall South, P.O. Box 94934
Lincoln, NE 68509

1-800-642-6112, 1-402-471-2024

TTY/TDD: 711

www.nol.org/home/NEOC/

NEVADA

Office for Civil Rights of the West

4126 Technology Way, Room 100
Carson City, NV 89706

1-800-368-1019, 1-415-437-8310

TTY/TDD: 1-415-437-8311

www.detr.state.nv.us

NEW HAMPSHIRE

New Hampshire Human Rights Commission

2 Chenell Dr.
Concord, NH 03301

1-603-271-2767

TTY/TDD: 711

www.state.nh.us/hrc

NEW JERSEY

Department of Law & Public Safety

P.O. Box 090
Trenton, NJ 08625-0090

1-609-292-4605

TTY/TDD: 1-609-292-1785

www.state.nh.us/hrc

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia) (con't)

NEW YORK

Office for Civil Rights

26 Federal Plaza, Suite 3313
New York, NY 10278

1-212-264-3313

TTY/TDD: 1-212-264-2355

Office for Civil Rights U.S. Department of Health and Human Services

Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278

1-212-264-3313

TTY/TDD: 1-212-264-2355

www.hhs.gov/ocr/office/

NORTH DAKOTA

North Dakota Dept. of Labor

600 E Boulevard Ave, Dept 406
Bismarck, ND 58505-0340

1-800-582-8032, 1-701-328-2660

TTY/TDD: 1-800-366-6889

www.nd.gov/labor/services/human-rights/

OHIO

Ohio Civil Rights Commission Central Office G. Michael Payton Exec. Direct.

30 East Broad Street, 5th Floor
Columbus, OH 43215

1-614-466-2785, 1-888-278-7101

TTY/TDD: 1-800-750-0750, 1-330-643-1488

<http://crc.ohio.gov/>

OKLAHOMA

Oklahoma Civil Rights Commission

2101 N Lincoln Blvd.
Oklahoma City, OK 73105

1-800-368-1019, 1-214-767-4057

TTY/TDD: 1-214-767-8940

www.onenet.net

OREGON

(See Washington listing)

PENNSYLVANIA

Office for Civil Rights, U.S. Department of Health and Human Services

150 S. Independence Mall West, Suite 372,
Public Ledger Building
Philadelphia, PA 19106-9111

1-800-368-1019, 1-215-861-4441

TTY/TDD: 1-215-861-4440

www.hhs.gov/ocr/office/

Pennsylvania Human Relations Commission

301 Chestnut Street, Suite 300
Harrisburg, PA 17101

1-717-787-4410

TTY/TDD: 1-717-783-9308

www.phrc.state.pa.us/

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia) (con't)

SOUTH DAKOTA

South Dakota Dept. of Commerce & Regulation Division of Human Rights

118 W Capital Ave.
Pierre, SD 57501

1-605-773-4493

TTY/TDD: 711

www.state.sd.us/dcr/hr

TENNESSEE

Tennessee Human Rights Commission

530 Church Street Suite 400, Cornerstone
Square Building
Nashville, TN 37243-0745

1-615-741-5825

TTY/TDD: 711

www.state.tn.us/humanrights/

TEXAS

Texas Commission on Human Rights

403 East Ben White Blvd.
Austin, TX 78704

1-800-572-2905

TTY/TDD: 711

www.dshs.state.tx.us

TEXAS

Office for Civil Rights U.S. Department of Health and Human Services

1301 Young Street, Suite 1169
Dallas, TX 75202

1-214-767-4056

TTY/TDD: 711

www.hhs.gov/ocr/office/

UTAH

Utah Anti-Discrimination Division

P.O. Box 146640, 160 East 300 South
3rd Floor
Salt Lake City, UT 84114-6640

1-801-530-6801

TTY/TDD: 711

www.laborcommission.utah.gov

VERMONT

Vermont Human Rights Commission

120 State Street
Montpelier, VT 05620-4301

1-800-368-1019, 1-617-565-1340

TTY/TDD: 1-617-565-1343

www.hrc.state.vt.us

VIRGINIA

Council on Human Rights Suite

1100 Bank St., Suite 11-202 Washington Bldg.
Richmond, VA 23219

1-804-225-2292, 1-800-633-5510

TTY/TDD: 711

www.chr.state.va.us

WASHINGTON

U.S. Department of Health and Human Services

2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831

1-800-368-1019, 1-206-615-2290

TTY/TDD: 1-206-615-2296

www.hhs.gov/ocr/office/

Civil Rights Commission Contact Information

6. (if you don't see your state, see District of Columbia) (con't)

Office for Civil Rights of Alaska, Idaho, Oregon, and Washington

2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831

1-800-368-1019, 1-206-615-2290

TTY/TDD: 1-206-615-2296

www.hhs.gov/ocr/office/

WISCONSIN

Wisconsin Equal Rights Division Dept. of Workforce Development

P.O. Box 8928, 201 E Washington Ave.
Room 407
Madison, WI 53708-8928

1-608-266-6860

TTY/TDD: 711

www.dwd.state.wi.us/er

WYOMING

Wyoming Department of Employment Labor Standards Fair Employment Program

1510 E. Pershing, West Wing, Suite 2015
Cheyenne, WY 82002

1-307-777-4103

TTY/TDD: 711

<http://wydoe.state.wy.us>